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ABSTRACT

Papers presented at the third annual conference on post-secondary paraprofessional education held at Pennsylvania State University in November 1971 centered around the human service occupations. This rapidly developing area of paraprofessional education will offer increasing job opportunities in the future in health, social service activities, and other fields. The conference's major objective was to provide an exchange of ideas among participating educators as to the role of 2-year colleges in planning programs in social- and health-related paraprofessional occupations. This report contains the conference program, registrants, evaluation, group discussions, and texts of eight papers. Topics covered by the papers include statewide planning for delivery of human and health services, health personnel training, licensing and certification, human services programs, and accreditation. (MF)

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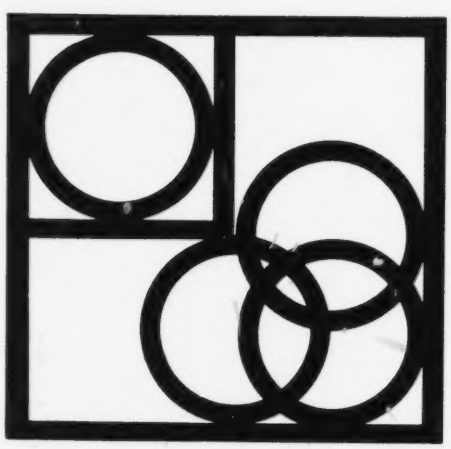
The Third Annual Pennsylvania Conference on Post-Secondary Occupational Education

Angelo C. Gillie
Editor



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The Third Annual Pennsylvania Conference on Post-Secondary Occupational Education

Angelo C. Gillie
Editor

Center for the Study of
Higher Education

The Pennsylvania State University
University Park, Pennsylvania

June 1972

Center for the Study of Higher Education

The Pennsylvania State University

The Center for the Study of Higher Education was established in January 1969 to study higher education as an area of scholarly inquiry and research. Its studies are designed not only to be relevant to the university and the Commonwealth of Pennsylvania, but also to colleges and universities throughout the nation. The immediate focus of the center's research falls into three broad areas--governance, graduate and professional education, and human service occupation programs in two-year colleges.

Research reports, monographs and position papers prepared by staff members of the center can be obtained on a limited basis. Inquiries should be addressed to the Center for the Study of Higher Education, 101 Rackley Building, The Pennsylvania State University, University Park, Pennsylvania 16802.

TABLE OF CONTENTS

FOREWORD	G. Lester Anderson	v
ACKNOWLEDGEMENTS		vii
INTRODUCTION	Angelo C. Gillie	1
Statewide Planning for Delivery of Human and Health Services	S. V. Martorana	9
Statewide Planning for Delivery of Human and Health Services: Some Concepts	Alex J. Ducanis	25
Health Care: System or Nonsystem with Implications for Training	Edward V. Ellis	38
Licensing and Certification of Health Services Personnel	Maryland Y. Pennell	49
Licensing and Certification: Another View	Douglas Whyte	74
Seeing is Believing, Planning is Projecting: Human Service Programs	Martha A. Burns	77
Accreditation of Human-Health Service Programs	Bob E. Childers	85
The Preparation of Educational Paraprofessionals	Daniel Carter	96
Evaluation of the Conference	John W. Glenn, Jr.	105

TABLE OF CONTENTS (CONT'D)

Appendix A:	Conference Program	115
Appendix B:	Registration List	123
Appendix C:	Conference Advisory Committee	133
Appendix D:	Questionnaire for Conference Evaluation and Follow-up Interview	137
Appendix E:	Reports of Discussion Groups	145
Appendix F:	"The Role of the University in the Preparation of Allied-Health Faculty for the Two-Year College - Michael N. Sugarman Reaction to S.V. Martorana Paper	163

FOREWORD

Occupational or paraprofessional education, post-secondary in character, increases in its significance in the world, year by year. The more rapidly developing area of paraprofessional education is that which has come to be known as the human service occupations area. This field developed later than the technical service occupations which rest largely on engineering and the sciences. The human service occupations, as they mature and develop, will rest on the social and behavioral sciences and the helping professions. It is becoming clear that the job opportunities for service in this paraprofessional area will increase markedly in the next decades -- in health, public service, social welfare, school centered activity, recreations, communication industries, business, and so on.

It is thus most timely that the third annual conference on post-secondary occupational education held on the Pennsylvania State University Campus (November 1971) should direct the attention of the participants to human service occupations. The Center for the Study of Higher Education is pleased once again to be a cooperating and supporting sponsor of the conference in service to higher education in the Commonwealth of Pennsylvania.

G. Lester Anderson
January 1972

ACKNOWLEDGEMENTS

Much credit for the original idea behind the conferences is owed to Mr. Robert Knoebel, who has recently retired from the Department of Education and is now serving as Executive Secretary of the Pennsylvania Community College Commission. Special acknowledgement is also due Mr. Robert Sheppard, Advisor for the Division of Two-Year Programs, Bureau of Academic Services of the Pennsylvania Department of Education. A tireless worker for the improvement of post-secondary occupational education opportunities in the Commonwealth of Pennsylvania, Mr. Sheppard has made a most significant contribution in time and effort to the planning and conducting of these conferences. He has served as Chairman of the Advisory Committee for the past three conferences and will again serve in that capacity for the fourth. The other advisory committee members, who have also contributed much toward making this conference successful, are listed by name and title in Appendix C.

The editor also wishes to express his deep appreciation to the Penn State Foundation, which helped support the conference and which funded the publication of the proceedings. He also wishes to thank the Center for the Study of Higher Education and its director, Dr. Anderson, whose funding has provided for the expenses associated with the administration of the past three conferences. Special thanks also go to Jane C. Peterson who supervised the final preparation of this manuscript.

INTRODUCTION

Angelo C. Gillie
Professor, Department of Vocational Education
and The Center for the Study of Higher Education
The Pennsylvania State University

This event is the third in an annual series relating to occupational education in post-secondary institutions. These conferences are designed to deal with national concerns in post-secondary education that are most relevant to the Pennsylvania two-year college occupational education effort. The first one, convened in October 1969, discussed "Post Secondary Occupational Education: An Overview and Strategies" among approximately thirty participants. "Evaluation of Post Secondary Occupational Education" was considered at the second conference held in November 1970. About seventy persons participated and it seemed to evoke considerable interest among the two-year college educators in the Commonwealth. The papers and proceedings of the most recent conference, held in November 1971, centered around the theme "Planning and Conducting Social and Health Related Service Programs," and are included in this monograph. Considering the overall goals of these conferences, the present level of participation, eighty conferees, is probably near its optimum level.

As would be expected, most of this year's eighty-two participants were educators (sixty-four conferees or 78 percent of the total). It is important to note that the number of administrators far exceeded the number of faculty members (fifty-three and eleven respectively). These statistics reinforce the appropriateness of aiming these events toward administrators. Also participating were five practitioners (i.e. individuals

who are working in relationship to social or medical agencies), five members of the State Department of Education, and eight graduate students.

The distribution of educational institutions and other agencies represented at the conference is worth noting. Only one of the fifteen community colleges (Reading Area Community College) was unrepresented. There were also participants from a number of other two-year colleges, bringing the total of represented two-year colleges to nineteen. (This included several private junior colleges, a proprietary two-year college, a two-year college from Maryland and representatives from the Virginia Community College System.) Other participants included representatives from five Pennsylvania area vocational-technical schools, three universities (Temple University, University of Akron, and State University of New York at Buffalo), one state college (State University College at Buffalo), one private four-year college (Spring Garden College), one skill center, and three hospital or hospital related organizations. We note with particular pleasure that the participants in this third conference included a wider diversity of institutions than did the previous events.

The evaluation results of each of these annual events lead us to believe that they are sufficiently attractive and useful to administrators and faculty concerned with post-secondary occupational education to continue them indefinitely. At the time of this writing, for example, an advisory committee is being formed to begin planning the fourth annual conference. Based on our evaluation of the third event and other feedback from occupational educators, the theme selected for the fourth conference, scheduled for October 1972, will deal with articulation, with special emphasis on articulation between the area vocational schools and two-year colleges.

The Advisory Committee, consisting of eleven active and two ex officio members, was carefully selected so as to insure representation from all the types of institutions which offer post-secondary occupational education. For this past conference, committee members were drawn from occupational program leaders in a variety of post-secondary institutions, including a four-year private college, a two-year proprietary type institution, the Commonwealth Campuses of The Pennsylvania State University, the public community colleges, the main campus of The Pennsylvania State University, and the Pennsylvania Department of Education.

The eight papers delivered at the conference are presented here in their entirety.

The conference's four major objectives were:

1. To consider the role of two-year colleges in the planning and providing of programs in social and health related paraprofessional occupations.

2. To provide the participants with information that would better enable them to identify some of the elements and useful approaches for planning and conducting such programs in their institutions.

3. To provide an opportunity for educators concerned with post-secondary occupational education to meet for the purpose of exchanging ideas and viewpoints on topics associated with social and health related service programs, particularly:

   a. state-wide planning for programs;
   b. licensing and certification of health service personnel;
   c. accreditation of social and health related service programs.

4. To continue with the series of cooperative ventures between the university and Pennsylvania post-secondary institutions which are aimed at contributing to the overall improvement of post-secondary occupational education.

Our topic, "Planning and Conducting Social and Health Related Programs," was selected because programs of this type are a major occupational program offering of the two-year colleges, particularly the public community colleges.

In 1966, 37 percent of Pennsylvania community colleges' total enrollment of 10,565 were enrolled in occupational programs and this has steadily climbed to 49.5 percent of 47,724 in 1970. The growth of occupational education programs is seen not only by the increased enrollments in the community colleges but also by the steadily increasing percentage of the total enrollments in occupational programs. The community colleges at the present time provide the major thrusts in occupational programs in the Commonwealth and will probably continue to do so.

ERRATA SHEET:

Pages 5 thru 8 should read pages 24A to 24D.

wages or salaries are so frequently lower than equivalent training and education in other fields.[3]

Whether or not one agrees with the solution he proposes in his article, it must be granted that Dr. Esty asks some important questions. In response, one suggestion that may be worthy of serious study among community college curriculum planners and statewide planners for the human and health services is that the problems of public and preventive health be incorporated into the general education curriculum content in these colleges.

Several reasons could be advanced in support of this suggestion. First, public and preventative health is, indeed, one of the major social problems of our day and thus merits inclusion in any program of general education which purports to be relevant to the times. Second, the exposure of a wider number of students to the issues surrounding health care could become an effective mechanism for recruiting more students in the health careers by awakening their interests and initiating new understanding. The community colleges are a proven agency for recruiting students to career fields through their counseling and guidance services. The opportunity they have to do this through development of curriculum and instructional themes in their general education programs, along with comparable efforts toward student orientation to these fields made earlier at high school levels, however, is as yet generally underperceived and underdeveloped. Statewide planning attention, therefore, may be well advised to turn its attention away from the current overwhelming concern about "articulation" between two- and four-year programs in both liberal arts and career fields toward a greater attention to the use of general education programs to enrich a student's education and to help him to find a lifework.

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[3]Geoffrey W. Esty, "Health Education in Our Schools and the Health Manpower Shortage," The Journal of School Health XL, 1 (January, 1970), p. 11.

My next concern asks you to examine the actions we are planning in response to the wave of credentialism that is threatening to engulf us. Surely this is not a matter that you as members of faculty or administration of individual colleges or as responsible officials of state agencies can comfortably leave to outside interests. The attention the subject is already attracting elsewhere should alert us to the seriousness of the potential impact of expanding credentialism. The Newman Study identifies the impact of credentialism and licensure as one of the most serious threats to flexibility and adoption of creative educational practices in all higher education. It is a particular threat to the traditional freedom of programming for the service characteristic of the community college. The Association of Schools of Allied Health sensed the problem so directly that it sought the help of the Commonwealth Fund, and together they are now conducting a study of programmatic accreditation of health service career training programs and of credentialism's impact on the programs these institutions are offering. The study, now underway, is being directed by Dr. William Selden, former Executive Director of the National Commission of Accrediting.

Most states already have some officially identified mechanism for assuring the reasonable quality of the programs offered by their schools and colleges and for assuring the entry qualifications of persons practicing in human and health service fields. Moreover, most colleges readily accept and seek the accreditation of the national regional accrediting agency that serves the region in which the college is located. With these two existing safeguards for quality of performance and capability of graduates from career programs, the need for additional safeguards is to be questioned. The questions may be better asked as a part of the general statewide planning for a complete delivery of education and training for these fields than in the examination of the fields as they are developed one by one in the implementation of the statewide plan after it is adopted.

My eighth and final concern is certainly not the least in the importance I attach to it. It is the need to recognize and provide for an ample supply of competent faculty to staff the programs proposed in a statewide plan for human and health-care services. Without a corps of able and dedicated faculty members to provide sound instruction in the career fields, no statewide plan can be effectively implemented. In New York state we have had repeated instances where community colleges have been approved to offer new programs in the health career fields only to have the date of initiation of the proposed curriculum delayed because a qualified instructor could not be located.

In this problem area, there is a special necessity and opportunity for effective cooperative effort involving two-year and four-year colleges and universities operating advanced professional schools. Most of the demand for instructors is at the community college level. In New York state, for example, the overwhelming proportion of instruction in the 126 health-related career fields is taught in the community colleges. These colleges enroll over 12,000 of the total of some 15,000 students enrolled in health related career fields. Yet the source of supply for these instructors obviously is the four-year colleges and the university centers. The need for a cooperative interinstitutional effort in recruiting, training, and placing instructors, therefore, is obvious. The joint effort must be directed not only at producing competent instructors in the required numbers. It must also provide that their competence is well balanced, assuring that they have both knowledge in their field of specialization and an attitude and understanding of the community college and the student it serves that befits faculty in these institutions.

Fortunately, there is an exemplary program in at least one place in New York state that I can suggest to you as a model. It is the Community College Health Careers Instructor Training Program centered at Buffalo. Here is a program that builds a service in instructor

development which is interstate and nationwide in its reach on a platform of two-year, four-year, and university level programs in health fields designed to serve western New York and in which the integrity and unique educational mission of each type of college is recognized and preserved. In this arrangement, faculty members in the community colleges serve as "clinical professors" to the instructor development programs offered in the University School of Allied Health. Members of the "health delivery team" studying at the university, including members of the faculty of the medical and dental schools, visit and provide instructional demonstrations at the surrounding community colleges in the region. It is, in short, a model that we are trying to get replicated in several other regions of the state and one that I commend for your further examination.

Conclusion: A Look to the Future

As I look back at this paper and recall that I said I would probably be raising more questions than I would answer about the process of statewide planning for human and health services education and training, I believe that I have fulfilled that prophecy. In the course of the discussion, however, I believe that you may find some observations and suggestions that can serve you well in your own planning efforts.

And on this note, I should like to conclude. Make no mistake, interinstitutional, regional, and statewide planning is here to stay. All of us would be well advised to become as knowledgeable as possible in the planning process and active in its implementation. Beyond this we must find ways to bring the various diverse subject matters of concern in the planning process, like health and human service careers, into a meaningful and integrated, more comprehensive planning effort that takes into account all post-high school education. This, in my view, is the major challenge of the day. The choice of your theme for this conference indicates your awareness of this challenge and your forward motion to meeting it. I wish you well.

STATEWIDE PLANNING FOR DELIVERY OF HUMAN AND HEALTH SERVICES

S. V. Martorana
Vice-Chancellor for Community Colleges and
Provost for Technical and Vocational Education
State University of New York

I feel indeed honored and privileged to be able to join with you in this third annual Penn State conference on post-secondary occupational education. In this era of rapid change, especially in education, any time an effort can be maintained for two years in a row, you can make claim to having established a new tradition. Since this conference in Pennsylvania is now in its third year, I suppose we should refer to it as a long-standing tradition. In all seriousness, all of you associated with Dr. Angelo Gillie in establishing and maintaining this annual event are to be congratulated. This conference gives persons in positions of leadership in education, not only in Pennsylvania but throughout the northeast, a badly needed opportunity to give serious study and recognition in depth to an area of post-secondary education that is increasing daily in magnitude of enrollment, in the complexity of problems it faces, and in the importance of its potential for service to our society.

Let me set you at ease right from the start as to my qualifications (or lack thereof) for appearing as your speaker today. I am not an expert in "human and health services" in general nor in any one of these fields of work in particular. So if you came prepared to hear and learn from a scholarly treatise on the technical problems of perfecting a complete delivery system of these services with high quality performance, you are bound to be disappointed. I am, however, somewhat experienced in the business of statewide and regional planning in higher education and in the establishment and operation of colleges and universities, especially two-year community and junior colleges.

It is in this context that I have organized the thoughts which I should like to share with you today. I must confess and alert you that they are not comfortable thoughts. Rather, they are somewhat disturbing to me as an official who carries in your neighboring state to the north some responsibility for bringing order and direction without conflict, broadened services without confusion of institutional purposes, and general expansion of post-high school institutions without increased costs. I am sharing these thoughts with you, not to burden you with the troublesome problems others face, but to seek a broader wisdom in their solution. I believe that these problems and concerns are general throughout the nation and not specific to New York State. Your deliberations at this conference and your later deliberations, studies, and program innovations on your home bases, therefore, may well provide the answers we are all seeking to the several tough questions we face in developing adequate and effective human and health care services today.

The several concerns in this area relate broadly to education for the human and health services at several levels -- high school through university. Within this general applicability, however, you are asked to focus on the place and role of the two-year college by whatever name it may be called -- community college, junior college, technical institute, area vocational school, etc. In my view, these are all manifestations of the same general educational phenomenon, which for the purposes of this presentation will be referred to generically as the two-year community college.

Eight Broad Concerns

In one way or another, all of us are involved and responsible for statewide planning for more effective delivery of human and health services. Whether one operates within the context of a single institution and is concerned primarily with its curriculum, services,

and student clientele, or whether one is dealing with a multicampus college or university or a state system of higher education, all of us today must realize the increasing interrelatedness of institutions and operations in higher education. The day of the isolated faculty and administration, operating unilaterally in setting the objectives and program of their college or university, is gone. Many forces are actively pushing educational institutions to examine their activities in consort and from the perspective of a statewide system. Not only is this true with respect to their involvement in providing human and health care services, but this applies to all aspects of institutional services and operations.

This being so, your attention should be called to eight concerns which, in my judgment, are creating complications in our pursuit to develop greater understanding of what our colleges can and should do and how they ought to proceed toward their goals in human and health service education.

First, there is the wedding of two notions, that of education and training of practitioners in fields of human and health care, with that of practice in the actual delivery of human and health care services. The proposition seems to be that all education and training of human and health care personnel must necessarily take place only where there can be a close conjunction with the practice of these services. Carried to this extreme, the proposition poses some real questions that appear hard to answer. For example, should social workers be trained only in comprehensive health science centers where there are also schools of medicine, dentistry, allied health, and others? What about programs in selected fields, like the associate degree, or technical nursing and x-ray technology, and others, that community colleges have developed to high quality in most cases in places quite distant from comprehensive health service centers? Do we dispense with the kind of thinking suggested by Delhi Agricultural and Technical College, a two-year college in the relatively sparsely settled

area of south central New York? Delhi is proposing that it provide students with a year or year-and-a-half of the basic sciences at its campus and then have the students spend a year, or semester and summer, in concentrated specialized study and clinical experience at an urban location where one of the state university medical centers is located.

Please do not misunderstand my purpose in presenting this concern. It is not to suggest that human and health care practitioners can be trained well without good, practical, clinical experience in their preparatory programs. To attempt this would be folly indeed. The concern is that the call to educate and train practitioners to become part of and to value their being a part of a "health services delivery team" can lead to the conclusion that unless a teaching-learning situation can be developed where *all* members of the "team" are trained at the same place, *no* member of the "team" can be educated and trained. My own view is that the success already recorded by community colleges in training some, but obviously not all members of the "team," suggests the fallacy of the proposition, if carried too far.

The second concern is really an extension of the first: it is the need for a sharper clarification of what is meant by "Area Health Education Centers." As is likely well known to this audience, for some time the administration in Washington has advocated legislative authority to establish a series of Area Health Education Centers, which has led to new types of linkages in our educational systems. The concept of such centers was promoted by the recent report of the Carnegie Commission on Higher Education. According to a statement included in a paper presented by Dr. Thomas D. Dublin, Chief, Program Evaluation Staff, Bureau of Health Manpower Education, National Institutes of Health, in June of this year, the purposes of Area Health Education Centers are to ". . . permit targeted attacks on one of the nation's major health manpower problems, namely, the problem of increasing personnel in underserved inner-city and rural areas. An AHEC would link more firmly educational institutions with health service organizations,

including community hospitals, to train needed health personnel, particularly for those underserved areas."

He went on in his paper to point out that they viewed an AHEC as a "new way of organizing things," and then stated four more specific functions for the centers as follows:

> It would be established primarily to conduct educational programs. Specifically, it would provide continuing education for area practitioners, residency training in primary care, undergraduate education in one or more health disciplines, and training of personnel as health-care teams.
>
> Secondly, an AHEC would aid educational and health-care institutions develop and expand their facilities and capabilities for the training of health personnel. This would include technical aid to institutions offering preprofessional education required for admission to health occupation courses.
>
> Thirdly, the consortia of educational and service institutions comprising an AHEC would provide ambulatory and inpatient medical services and act as a referral center for other patient-care resources in an area.
>
> Fourthly, an AHEC would foster and assist in the manpower planning and implementation of effective health-care delivery systems for an area.

Finally, I should note for your attention that Dr. Dublin stated that "Most AHEC's would directly involve one or more medical schools but this, too, would not be a necessary requirement." In this connection, he emphasized that the NIH projections of area health educational centers were less restrictive than the Carnegie Commission proposal that such centers be "captive"

satellites of university health science centers. He went on to make this statement which presents much food for thought for all of you who are interested in playing an active role in developing a truly statewide plan for delivery of human and health services. He said:

> We believe that medical schools have much to gain from these centers, and where appropriate they should take the initiative in getting them launched and invest their strength in maintaining their operation on a high level of educational excellence. On the other hand, we believe also that there is room for local community-centered initiative which can and will turn to one or more university health science centers drawing them into the planning and operational bases of the AHEC's as truly cooperative enterprises.

It is not clear where this leaves the community colleges as agencies that are ready, willing, and able to offer quality programs to train workers through the technician level to be part of the human and health services delivery team. You would be well advised, however, to establish early working rapport with any so-called "lead agency" in your locality or region within a state, such agencies being "any group capable of setting up and operating an AHEC with the aid of federal finances." Indeed, in some areas, particularly rural ones, it does not seem inconceivable that a community college could well be such a "lead agency."

At any rate, if a pattern of regionalized Area Health Education Centers is to be developed, it seems obvious that, not only will all available institutional programs and services be taken into account, but that this will be done in a way that maximizes the special educational commitments and capabilities that each cooperating institution can bring to the centers. Thus, two-year community colleges, four-year colleges, and university graduate centers and professional schools will be associated with each other and with related non-educational community health service agencies to produce

a complete capacity for education and training with a minimum of costs and commitment of scarce human and material resources.

This takes me to my third concern: the challenge of reconciling our needs to plan a coherent, efficient, and economical structure and procedure to train human and health service personnel and at the same time to plan comparably to meet other educational demands of the society. Regional planning within states seems to be the order of the day. It is happening in California, Texas, Michigan, and in a long list of other states. In New York, it is literally the "order of the day," for last February, Governor Rockefeller issued an executive order calling on all agencies in charge of state programs and services to base their future long-range plans on a regional division of the state developed by the Office of Regional Services. The State University of New York, whose long-range plans for the locally controlled community colleges must be formulated within a statewide master plan, and the Board of Regents and the State Education Department, where all educational planning is coordinated, are obligated to adhere to this gubernatorial directive.

Now the big question of obvious concern to you participants in this conference is this: How do we go about tying together in some rational way the great push toward regional planning of education, training, and delivery of human and health-care services with the strengthening push to put all governmental projections and decision making on a regional and statewide basis? Do we ask the planners in other areas of social and economic concern in a state -- the highway planners, the community development planners, the housing planners, etc. -- to adjust their designs to our premises and objectives? Or do we adjust what is going on in the human and health services fields to the outcomes of their deliberations? Is an early getting-together of all planning interests -- local, regional, statewide -- another and wiser alternative?

Let me illustrate the complexities that seem to be set in motion under present approaches to regional planning by referring to just one area in New York State. The public and private colleges in the area around Rochester have been working together in a consortium arrangement for some ten years. The group of institutions includes the University of Rochester, which operates a medical school; several four-year liberal arts colleges, some public, some privately controlled; and Monroe Community College, which is sponsored by Monroe County where the city of Rochester is located. Last year, this consortium of institutions went to and received a charter from the Regents to authorize them to work even more closely toward mutually desired goals.

Then, very early this year, quite independently of the consortium of higher educational institutions (although with some communication with it), the Genesee Region Educational Alliance for Health Personnel, Inc. was founded. The geographic reach of the Alliance covers ten counties and overlaps quite completely the area handled by the collegiate consortium. As of March 1, 1971, thirty-seven member organizations had paid dues to the Alliance and partial staffing of its program had been provided by the Commonwealth Fund. You will be interested in the following excerpts from the proposal on which the Alliance was founded.

Objectives:

1. To develop short- and long-range plans for meeting the educational needs for health manpower in the Genesee Region, with provision for periodic review.

2. To disseminate in the health education field the latest advances in teaching techniques.

3. To encourage the coordination of curricula at one level with those at higher levels so as to provide steps toward the creation of career ladders in health by eliminating needless repetition of requirements.

4. To encourage each member institution to develop and expand programs which will make the best possible use of its particular strengths.

5. To encourage member institutions to share faculties, facilities, and other resources in order to achieve economies and expand educational opportunities.

6. To encourage and assist experimental and demonstration efforts in shortening or making more effective the training of existing categories of health manpower as well as in the addition of new categories of health personnel.

7. To encourage improved patterns for use of clinical and other resources for student learning experiences.

8. To cooperate with existing professional and educational groups in obtaining such information, program concepts, and program goals as will assist in achieving the above purpose and objectives.

Member Organizations

All organizations in the region, providing formal education in the health care field as well as those offering opportunities for practical educational experience, will be invited to membership in the Genesee Region Educational Alliance for Health Personnel. These will include colleges, universities, hospitals, nursing homes, homes for the aged, high schools, and vocational schools as well as other health service organizations providing field training opportunities for students in health careers. Since membership in the Alliance will constitute a commitment by each member organization to regional coordination of its educational and related programs, approval by its governing authority will be necessary.

Autonomy of the New Organization

> The Genesee Region Educational Alliance for Health Personnel will be autonomous to assure maximum freedom of speech and action. Liaison will be maintained with other organizations who may help the Alliance. For example, the Chairman of the Manpower Committee of the Genesee Region Health Planning Council might be a member of the Alliance Board.

Now, under the governor's executive order which I have already mentioned, the same Rochester-Monroe-Genesee Region is under examination by the State University of New York, the Regents, and the State Education Department in terms of the work they need to do in developing their 1972 master plans.

Again the question must be asked: How can and will all of this planning effort be pulled together, especially when the autonomy of some is so emphatically stated as in the case of the Genesee Alliance? What are the implications for the possible emergence of an even greater insistence at a higher level of state government that communication among planning agencies be developed and maintained? What will ultimately come from the interaction of these factors and federal governmental programs with their typical requirements that requests for funds be based on regional and statewide plans?

In order that a duly recognized role be given to post-secondary institutions (like community colleges) in the search for programmatic answers to questions like these, it is imperative that persons in responsible positions in these institutions seek a leadership role. That this can be done is being evidenced in many ways. This conference is one. Another is the kind of work being done by persons like Mrs. Phyllis Higley, Acting Chairman of the Department of Allied Health Teacher Preparation at the School of Allied Health at the State University of New York at Buffalo, and Mr. Robert Love, Chairman of the Division of Health Technologies, at

the State University of New York Agricultural and Technical College at Alfred. Mrs. Higley is now in the final stages of a significant study of how decision makers in two- and four-year colleges that are involved in developing a coordinated allied health program of studies in western New York exchange information and formulate offerings that build on institutional strengths and are mutually reinforcing. The study is moving forward with the endorsement of the Office of the Vice-Chancellor for Two-Year Colleges and the support of the University School of Allied Health. Mr. Love was a key figure in the formation of a statewide association of faculty involved in allied health in the two-year colleges. This association is giving its attention to means for perfecting statewide and regional program development with maximum coordination. Mr. Love is also a member of the advisory committee which is helping to guide Mrs. Higley's study.

The fourth concern we need to examine very closely is the "state of the art" in providing information about health manpower needs at local, state, and federal levels. Without sound, reliable data on manpower requirements, the educational planning and curriculum development proceed as if on a base of quicksand. We need at least two types of data to quickly identify new developments and emerging trends in career development in human and health service fields. One type is the straight statistical reports and analyses of job types that are needed to deliver adequate services to the society -- data as to what personnel is needed, in what numbers, how fast. The other is information regarding the education and experience each worker in human and health services should complete before he is permitted to seek initial employment as a practitioner in his field.

To my knowledge, neither of these two types of basic planning and decision making data is available in sufficient quantity and depth of analysis to generate strong confidence in our regional and statewide program plans. The available information is quite murky and ambiguous even on the local level and, therefore, even individual institutional planning, that

which is closest to local community needs, is carried on with much trembling and fear at heart.

These negative observations are not new. Awareness that this was the case prompted the Bureau of Health Manpower Education of the National Institutes of Health over a year ago to group its data-gathering and analysis operations into a new division, the Division of Manpower Intelligence. It is expected to serve as the focal point for developing, reporting, and interpreting all health manpower data in the federal government. If it achieves this objective, we in the field will be helped tremendously.

Even if adequate information is made available with respect to national needs and trends, however, there will still remain the need to have comparable information concerning the health and human services personnel requirements to meet state and local needs. As a general rule, it is lacking, even in states which take great pride in the advance status and level of sophistication reached by their data-gathering agencies. Under a grant from the Office of Economic Opportunity, New York was one of six states helped last year to take a closer look at the ways in which community colleges -- individually, regionally, and as statewide systems -- were marshalling their resources and programs to provide a better attack on poverty. As you would expect, one of the subject fields examined was that of health-care needs and the adequacy and availability of programs to train personnel to be sensitive and able to care for them. After a great deal of searching through information -- compiled by state agencies such as the Departments of Labor, Education, Health, Mental Hygiene, and Commerce, our study staff had to conclude that already-compiled information on the subject was simply not at hand. The effort, however, did disclose the fact that some census-type information was being taken on persons seeking employment. We used this as a point of departure for projecting an expanded data bank on this group of obviously economically deprived personnel which included some indications of health-care needs.

My examination of the literature in preparation for this paper suggests a conclusion that there are now some 150 different career fields which offer opportunities for specialization in allied health. As one person, actively engaged in the attempt to relate meaningfully the emergence of new fields of allied health to available data on manpower needs and employment practices recently observed, I see a "plethora of new health careers," but she also emphasized that they do not match the indications of need from the actual world of work as well as they might.[1] Unless this condition is rectified very quickly there could soon be a real danger of preparing persons for fields of work that do not exist in the local human and health services institutions and agencies.

In this connection, this conference may well wish to deliberate during its later sessions on the present state of understanding of the so-called "career ladder." Although people generally agree with the concept of a career-ladder approach to helping individuals develop personal and economic upward mobility, actual examples of career fields where the concept is operational are hard to find.

Moreover, the concept itself is still in the process of definition. Most commonly it suggests a step-by-step progression of jobs in which each job provides a foundation of required skills, understandings, and performance responsibilities upon which the next higher and broader set of duties rests -- with a comparable hierarchical expectation of education and training for each job on the ladder. Usually the concept also implies that once started on the ladder, the individual must aspire to the top rung, or admit to being either incompetent or unambitious.

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[1] Shirley J. Taylor, Planning Associate, Areawide and Local Planning for Health Action, Inc., Regional Comprehensive Health Planning Agency, Syracuse, New York in speech to State University of New York Conference on Allied Health Professions, September 16, 1971.

Again I must refer to Robert Love in presenting some reservations concerning this concept and its relation to both the substance of education and training for human and health services and the quantitative aspects of manpower -- the two types of data I have indicated as essential to good planning in this area. Speaking before a conference of allied health educators, Love offered these three observations on the career-ladder concept as cautions that it be kept as a positive force in our educational thinking and not be permitted to become another negative constraint. He indicated first that a greater importance should be attached to the development of "occupational competence" at each level of the career field rather than to the coordination of the education, training, and work experience at one level with those requisite for effective service at the next level. In other words, he was pleading for safeguards against the possible sacrifice of sound job entry preparation for the possible progression of the individual worker to the next upward job title. Second, he emphasized that the interest in developing a sound career-ladder design in a field should not cause developers of new curriculae and related instructional content to be less flexible and innovative than they otherwise might be if they were concerned solely with the individual student and his employability. Finally, he stressed that the career ladder should be viewed not so much as a straight ladder on which, once placed, the climber must either continue upward or fall off, but rather as a "staircase" from which the individual has a full opportunity to step off at any desired floor with valid and appropriate awards and labels for his achievement, including potential for service at the particular level of his choice.[2] All three observations are well worth your considered study and thought.

The fifth concern basic to our efforts today is one which I shall touch upon only briefly, for I frankly do not see much that can be done about it. Perhaps your

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[2]Robert L. Love, Chairman, Health Technologies Division, SUNY Agricultural and Technical College, Alfred, N.Y., speech at State University Conference on Allied Health Professions, September 16, 1971.

deliberations can provide some answers that can be constructively used in our continuing planning efforts. I refer to the growing bureaucracy at the federal governmental level. Mr. Thomas Hatch, Director, Division of Allied Health Professions, Bureau of Health Manpower Education, National Institutes of Health, reports that there are now forty-six federal agencies involved in over 125 programs touching on health training and that collectively these programs are handling about a billion dollars of federal funds.

Without a doubt, the policies and operational regulations of these agencies, as they make federal dollars available to local and state institutions, will affect the planning and general behavior of these institutions. I cannot understand, however, how responsible college and state level educational planners can relate their efforts to the widely varied intents and procedural requirements of nearly fifty different federal agencies in developing a sane and coherent local, regional, and statewide delivery system of education and training for human and health services. Perhaps the soundest approach to suggest is that spokesmen for individual colleges and for statewide systems join together in impressing upon the Congress and the executive agencies of the federal government the need for rapid acceleration of some efforts now underway to accomplish some interagency and interprogram coordination at the federal level itself. Federal guidelines to operating local and state institutions could then perhaps serve a more positively reinforcing influence on our planning at the local and state levels than is now the case.

The five concerns in statewide planning which have been discussed thus far have, in a sense, asked you to look from your institutions outward, to be sensitive to and preparing responses in statewide planning to forces that are more or less outside your control as participants in the planning process. The next three matters that I should like to present for your consideration as planners in human and health services suggest a more inward look.

These are, in my judgment, as forceful and important factors to be remembered in the planning process as those already covered. They are included in this paper, because I believe very deeply that unless our plans take them into account sharply and seriously much of the planning energy will come to naught.

The first of these, and the sixth in the total list of concerns, is the need to be concerned with the recruitment of students for the human and health service careers. I know very well that many of these careers currently have a glamour appeal and attract students in greater numbers than there are places in the programs. Nonetheless, this "open marketplace" approach seems both inconsistent with the whole idea of a well-planned organized educational enterprise and unreliable in its potential results. It would appear that a much sounder approach to effective statewide planning would be to make student awareness and interest in the several human and health service career fields a fundamental and integral part of the plan.

Dr. Geoffrey W. Esty is one writer who doubts that currently used techniques will furnish enough new recruits to health service manpower to meet the nation's needs. Writing in the Journal of School Health, he says:

> Somehow, we must now make every effort to explore and analyze those educational processes in the elementary and particularly in high schools, which will render young people susceptible to entering health careers in the face of intense recruitment for other important fields.

And he goes on to observe:

> Unless health education is experientially oriented and relevant to individual needs, freely expressed, one can hardly expect the student to become motivated to enter into one of the health careers. In any event, the former luster accompanying the professional health fields can hardly be expected to compensate for the additional expense and training time involved, especially when starting

STATEWIDE PLANNING FOR DELIVERY OF HUMAN HEALTH SERVICES: SOME CONCEPTS

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Several facets of the planning concept receive little attention, either by unconscious default or conscious design. First among these is the concept of planning itself and why there is a need for it, second, consideration of the means of implementing plans. Third, we must ask what factors in the health care scene should be of most concern to us in the near and distant future. And finally, we need to examine some elements which seem to be emerging in planning health care.

The thoughts I express here stem from some of my work with the planning process, and from my feeling of angst when the concept of planning is discussed. This anxiety generally derives from either of two causes: one, that planning is conceptualized as a very orderly, straightforward process which may be clearly described in a flow chart or some such manner; or, that planning as such is impossible in an open society. I would hold that neither contention is entirely true.

Planning is a means of rational assessment of what it is we wish to do or be and the means necessary to reach that state. (Too often it deals only with the former and not the latter.) In this sense, it is a process of deciding which of several alternative futures we wish to have. This concept is an important one. Though the concept of alternatives is central to planning, it often goes unrecognized, especially by those "planners" who are so bound to their own

systems of thought that they do not recognize opposition to their plans as possible expressions of *acceptable alternative futures*. Planning, then, is the process by which we determine the acceptable alternative futures. As such, it must be an active process in which we continually attempt to resolve what our current actions mean in terms of what futures they will produce. Generally, this portion of the process goes under the rubric of projection. Second in the process is a comparison of the results of current action with possibly more acceptable results. Third is a process of assessing the possible courses of action to reach the desired alternative. And last is the process of choosing which course to follow.

Please note that at each stage of the process the operant phrases contain the words *alternative, acceptable,* or *desirable*. We should then add the phrases "acceptable to whom," "desired by whom." The real question in planning is to determine the acceptability, in our society, of various futures, and the acceptability of various means of expending our effort or resources to reach them. This model of course assumes an open political system where many (more or less) share in the process. Planning, therefore, is a political process in the best sense of the word. As Mott stated it:

> The actions of planning agencies to get others to accept the changes they seek and the countervailing efforts of those who see things differently is a political struggle in which each party seeks to determine the outcome of the planning process according to its views of what should be done with respect to the matters that interest it.[1]

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[1]Basil J. Mott, "The Myth of Planning Without Politics," Journal of Public Health, 59 (May 1969):797.

What we have, then, is a process by which we decide what is most acceptable to most parties both in terms of choosing an alternative future and a means of procuring it. One may immediately see the problems inherent in this type of planning model: it may lead to a choice of alternatives which are acceptable to the individual or to most groups but disasterous to society as a whole. Hardin has called this the "tragedy of the commons." Simply stated, his thesis is as follows (by the way, for "herdsman" you may read "institution" if you wish):

> The tragedy of the commons develops in this way. Picture a pasture open to all. It is to be expected that each herdsman will try to keep as many cattle as possible on the commons. Such an arrangement may work reasonably satisfactorily for centuries because tribal wars, poaching, and disease keep the numbers of both man and beast well below the carrying capacity of the land. Finally, however, comes the day of reckoning; that is, the day when the long-desired goal of social stability becomes a reality. At this point, the inherent logic of the commons remorselessly generates tragedy.
>
> As a rational being, each herdsman seeks to maximize his gain. Explicitly or implicitly, more or less consciously, he asks, "What is the utility *to me* of adding one more animal to my herd?" This utility has one negative and one positive component.
>
> 1. The positive component is a function of the increment of one animal. Since the herdsman receives all the proceeds from the sale of the additional animal, the positive utility is nearly +1.

2. The negative component is a function of the additional overgrazing created by one more animal. Since, however, the effects of overgrazing are shared by all the herdsmen, the negative utility for any particular decision-making herdsman is only a fraction of -1.

Adding together the component partial utilities, the rational herdsman concludes that the only sensible course for him to pursue is to add another animal to his herd-- and another, and another....But this is the conclusion reached by each and every rational herdsman sharing a commons. Therein is the tragedy. Each man is locked into a system that compels him to increase his herd without limit--in a world that is limited. Ruin is the destination toward which all men rush, each pursuing his own best interest in a society that believes in the freedom of the commons. Freedom in a commons brings ruin to all.[2]

If, then, such freedom leads to ruin, how do we prevent ruin? How do we proceed to plan in a free society? Let us compare two systems as outlined by Lindblom in his article "The Science of Muddling Through." He posits that there are essentially two approaches to planning: the Rational Comprehensive and the Successive Limited Comparative. The following are the characteristics of each.

Rational-Comprehensive

1a. Clarification of values or objectives distinct from and usually prerequisite to empirical analysis of alternative policies.

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[2]Garret Hardin, "The Tragedy of the Commons," Science 162 (December 13, 1968):1244.

[3]Charles E. Lindblom, "The Science of Muddling Through," Public Administration Review 19 (Spring, 1959):81.

2a. Policy formulation is therefore approached through means-end analysis: first the ends are isolated; then the means to achieve them are sought.

3a. The test of a "good" policy is that it can be shown to be the most appropriate means to desired ends.

4a. Analysis is comprehensive; every important relevant factor is taken into account.

5a. Theory is often heavily relied upon.

Successive Limited Comparisons

1b. Selection of value goals and empirical analysis of the needed action are not distinct from one another but are closely intertwined.

2b. Since means and ends are not distinct, means-end analysis is often inappropriate or limited.

3b. The test of a "good" policy is typically that various analysts find themselves directly agreeing on a policy (without their agreeing that it is the most appropriate means to an agreed objective).

4b. Analysis is drastically limited:

i) Important possible outcomes are neglected.

ii) Important alternative potential policies are neglected.

iii) Important affected values are neglected.

5b. A succession of comparisons greatly reduces or eliminates reliance on theory.

It seems to me that the Successive Limited Comparisons Method is the current practice in health planning and that, if it continues to be the procedure of choice, it may well lead to the tragedy of the commons. However, I very much doubt that we shall ever move to the Rational-Comprehensive system; instead I think we will reach a compromise or mixed mode.

How then could health planning best operate in our society? I think several principles may be followed which may tend to maximize the effectiveness of the process.

1. It should be continuous.

2. It should be in concert with its context.

3. Professional planners should not plan.

4. It should involve those affected.

5. It should be a means of identification and assessment of alternatives, and identification of and assessment of how to reach alternatives.

6. Planning should be a series of successive approximations.

7. Implementations should include the development of a reward system.

The Planning Process

The nature of planning dictates continuous attention. Presentation of a plan at any one point in time does not arrest the process but merely reports the current status of planning. Planning should be a long-term, low-key affair.

Contextual Awareness

The planning process of necessity must recognize the existing situation on both a current and historical basis, because planning takes place within that context and will, in turn, change the contextual variables. In addition to an assessment of the current situation, there should be a recognition of those factors over which the planner has varying control, e.g., birth rate, governmental policy. And here I call attention to a subtle point concerning the planning process, that being the difference between planning for a given projected future and planning for *alternative* futures.

Planners

It is my belief that the function of professional "planners" is not to plan as we have defined planning, but rather to develop the best strategy for the identification of the alternatives. We are now at the threshold of an era where analysis and/or simulation techniques are *beginning* to be useful aids to planning.

Involvement of Those Affected

If we are to do more than pay lip service to our stated policy of democracy, then there must be a serious effort to seek and accept the involvement of those who have some interest in the results of the plan. All who are concerned with the development of health care have an important stake in planning. All deserve an opportunity to participate in the planning process. The "planning" group has a responsibility to facilitate planning, not to assume exclusive responsibility for planning. Involvement prevents error as a result of ignoring relevant input; also it is more likely to insure knowledge of and commitment to the plan.

Identification of Alternatives and Their Implementation

Planning forces us to focus on alternatives and to define means for reaching those alternatives. Through re-examination of our goals and objectives, we define more precisely why we are doing what we are doing. It permits us to examine the possible alternatives and to implement those which promise best results.

A Series of Successive Approximations

Planning is a means of moving toward goals, many of which cannot always be detailed in the initial stages. A generalized goal may not be sharply defined in many aspects. The development of a plan does not presume a stasis situation; plans must be reviewed periodically.

Development of a Reward System

Finally, and perhaps most importantly, planning should be a means of defining a reward scheme which will redefine the existing system to reach specific alternatives. Simply stated, I do not believe we can change the system through an application of the Rational Comprehensive Method. I do believe, however, that we can change systems in a salutary way by judicious application of funds in a coherent manner consistent with the future we choose.

Current Concern

A recognition of the need for planning in the area of health care seems to be emerging at this time. There are, of course, several social factors influencing this:

1. the concept of health care as a right rather than as a privilege
2. the concept of consumer input into the planning of service

3. the rising demands of the poor, the black, and the deprived for a larger share of the wealth our technology has created

4. an increasing awareness of the interrelatedness of man and his environment

5. an increasing skepticism toward the institution of new technology without assessment of its impact upon the environment

6. fragmentation of care

7. the awareness of a need for more humanization of the world in which we live.

We have seen a major change in the expectations of our society in relation to health care. Whereas care was previously thought of as a privilege for the affluent, it is now conceived of as a right for all mankind -- an unfulfilled right, as a matter of fact. The implications of this concept are far reaching, for if we were actually to try to extend an adequate level of care to our population, the nascent problems of manpower and other resources would be exacerbated beyond belief. Given the current level of resources if the principle is extended beyond our national borders, the problem becomes ludicrous.

I probably need not rehearse the health statistics which indicate the United States is not as well off as it might like to believe. We have established a major national goal of making quality health care available to all. Daniel Moynihan has indicated the trouble with national goals (whether explicit or implicit).

> The difficulty with national goals is that they too quickly become standards by which to judge not the future but the present. In a sense, they institutionalize the creation of discontent.

> The setting of future goals, no matter how distant, drains legitimacy from present conditions.[4]

A second factor which is beginning to make itself felt in health care planning is the rise of the consumer as a participant in the planning process. Consumers of health care are beginning to feel that unless they have some say as to how they are to be cared for, they are not going to be as well taken care of. As might be expected, this participation leads to certain problems.

A third related factor which will affect health planning in the future is the current neglect of rather large segments of our population. If we do not have people who are actually starving, we do have both malnourished and undernourished people. The lack of adequate care facilities in our rural areas and in our inner cities is now recognized by many of those who have been neglected, and they are beginning to demand what we now think of as a right.

A fourth factor is that we have suddenly discovered that we must take care not to make our environment untenable for humans. The current concern is of course good -- the evaluation of the word *ecology* to the status of the word *motherhood* is all to the good; however, I hope that the current concern will take rational account of reality and not drive us to irrational retreat to a pastoral past that, indeed, never existed. As Etzioni puts it:

> The complicated problems that pollution control poses can be handled only in part through a crash program. Public and legislative commitment ought to be built up for a long pull. But even if one day, water and air again are as pure as they were before

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[4]Philip H. Abelson, "The National Goals Research Staff Report," Science 169 (August 7, 1970): 721.

man polluted them, many other environmental problems -- from ugly cities to overcrowding -- will still be with us.

Now we should continue to give top priority to "unfashionable" human problems. Fighting hunger, malnutrition, and rats should be given priority over saving wildlife, and improving our schools over constructing waste disposal systems. If we must turn to "environment," first attention should be given to the 57,000 Americans who will lose their lives on the roads in 1970.[5]

Concomitantly, we may make a related fifth point which is that we have begun to view technological advances with increasing skepticism unless we have a full assessment of their impacts on the environment. The cry about the steamboat was that it wouldn't work, not that it shouldn't. The cry against the SST was *not* that it wouldn't work, but that it shouldn't. There is also a growing awareness that technological solutions may not always answer human problems and that Adam Smith may need some re-examination, especially in areas such as the delivery of health care.

Related to the above is a sixth factor. Many individuals feel that health care is in danger of being fragmented to the extent that the individual is no longer considered as such and that there is no one who knows him as a whole.

Last, there is a growing awareness that we must begin to develop what we term a more *humanized* society, and here we generally mean the best qualities of the human animal rather than the worst. In order to accommodate for this in the human health services, we must begin to make the individual and his health needs central in our planning in both the area of education

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[5]Amitai Etzioni, "The Wrong Top Priority," Science 168 (May 22, 1970): 921.

and in the area of health care delivery systems. We must develop systems in relation to human needs rather than develop the human in relation to the system's needs.

What seems to be emerging?

1. recognition that the current system (or non-system) is inadequate to provide satisfactory health care for all

2. recognition that the continuation of current financing mechanisms *in vacuo* where costs are guaranteed will only exacerbate the problem of providing adequate health care

3. growing awareness of the relationships between technology, health care needs, manpower, and resources

4. the development of the concept of *health* care rather than *disease* care as an objective

5. the development of positive efforts to assess the consequences of various alternative actions upon the health care system

6. the growing awareness of the need to reorient the education of health professionals, especially in the area of understanding the social context in which they function

7. the growing awareness of the need to reorient the consumer with regard to maintaining his own health through his own actions or "non-crises" contacts with the system

8. greater emphasis on rational planning on the macro level with regard to the interrelatedness of the health care system and with adequate regard for the need to develop rewards to which the system will respond.

In conclusion, it seems to me that the time is past for recitation of the needed *numbers* of various categories of health care workers. The time is here for re-examining and directing the entire system, and the means for doing that is through the development of a reward strategy.

HEALTH CARE: SYSTEM OR NONSYSTEM WITH IMPLICATIONS FOR TRAINING

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National Health Care Crisis

One of the hottest issues of the day deals with health care as a right rather than a privilege. The uncertainty in the title of this presentation through the use of the phrase "system or nonsystem" is related directly to this concept. It is my contention that we do not have anything approaching a system for health care. What we have had in the past and what we now have today is a nonsystem with its pluralistic and independent nature -- a design which favors the privileged. We must devote our attention in the 70s to pulling the pieces together if we are to realize the most effective use of our health resources and provide quality health care as a right for a population expected to reach 250 million by the end of this decade.

The health care situation in our country today is in a state of crisis that challenges the existing policies and designs. As you know, the health of our citizens today is considered to be worse than it was fifteen or twenty years ago as compared to other industrial countries.

For example, the U.S. ranks:

1. fourteenth among industrial countries in the death of infants during the first year of life.

2. eleventh in the percentage of mothers who die in childbirth.

3. twenty-second in the life expectancy of males and seventh for females.

4. fifteenth in the death rate of males in their middle years.

The many problems that contribute to this crisis could be subsumed under four categories. These causes of crisis are, of course, interrelated and cannot be dealt with separately:

1. national shortages in various categories of health manpower and facilities

2. inadequacies in the system for the availability and delivery of care

3. lack of sufficient controls for the assurance of quality of care

4. steeply rising costs and their financing.

One brief look at costs is sufficient to validate the need for a national comprehensive and interrelated approach to solving our health care problems.

We are spending more than 150 percent as much for health care as we did ten years ago. In 1970, the health care expenditure was 67.2 billion as compared to 12 billion in 1950. For this period, the total health care expenditures rose an average of 8.8 percent per year -- an average of 12.2 percent in the last three years.

At this rate, expenditures will exceed 100 billion annually by the mid-seventies. On the basis of estimates by the Social Security Administration, costs would be 111-120 billion by 1975 and 156-189 billion by 1980.

National Policy and Design for Health Care

To deal effectively with the crisis in health care, it is imperative rather than optional that we develop a national policy and design for health care. We are still in a developing state relative to such a national policy and design for health care. It is probably safe to say that the basic mechanism will be a national insurance program of some kind. In that vein, it might be appropriate to review the major insurance-design proposals. The question now is not so much whether we will have a national insurance program, but what will be the precise mechanism and when will we get it.

1. The Health Insurance Association of America has introduced what is referred to as the "Healthcare" proposal. This plan would expand insurance protection by allowing tax benefits for premium payments. The federal government would buy insurance for families paying less than $300 federal income tax per year. In this plan, the delivery of health care would not be changed. Medicare would remain intact; however, some portions of Medicaid would be absorbed.

2. The American Medical Association has a similar plan through its "Medicredit" proposal that calls for an expansion of the purchase of private insurance. Those under sixty-five with no tax liability could obtain a certificate to be used in paying the full premium. Others could receive a credit offset against taxes or a certificate for premium payment to private insurance agencies.

3. Senator Jacob Javits of New York has introduced a proposal that would expand Medicare to cover the total population. This proposal's two principal features would be a national health insurance financed by private industry or the federal government, and improvement of health

care delivery through local comprehensive health service plans.

4. The "Health Security" proposal, commonly referred to as the Kennedy-Griffiths plan, would create a comprehensive national health insurance system. Its features would be to make health services available to all without a means test, and to provide for improvement of delivery and resources.

5. President Nixon's plan known as a "National Health Strategy" includes three major provisions:

   (a) insurance program for employed persons and for low-income families.

   (b) improvement of delivery through the development of "Health Maintenance Organizations" (HMOs).

   (c) support for health manpower programs.

6. Senator Russell Long of Louisiana has submitted a proposal for a national "Catastrophic Illness Expense Plan." This plan would supplement private insurance protection for almost everyone under sixty-five and for those under the Medicaid program. It would not deal with the needs of other health care components.

The Committee for National Health Insurance has suggested ten guidelines that should be considered in weighing the relative merits of the many proposals we now have before us. These guidelines should help in designing the most appropriate plan to meet our health care needs.

1. The whole population should be eligible for all the benefits of the program, according to the need for health care without financial tests or barriers.

2. The program should undertake to assure the availability of all useful and promising medical care services within the spectrum of its benefits.

3. The desired organizational pattern and delivery system should, as a practical matter, be achieved on an evolutionary course which starts with acceptance of current patterns and practices, and with provided incentives and supports for developments toward the declared goals.

4. The national economy as a whole should be the underlying source of financing, both for the development of needed resources for the provision of services, and for adequate and assured support of continuing functional performances.

5. To be acceptable as well as viable, the program design should be based on a partnership of (a) national public financing, and (b) private provision of medical care services, through self-selected diversities among providers of services, their locations, organizations, professional and fiscal operations, and participation in planning and administration.

6. Continuing financial supports should be assured through (a) taxes which are earmarked for medical care and which automatically adjust to the state of the national economy, (b) matching or supporting appropriations from general revenues, made as nearly automatic as possible, and (c) utilization of the total yield through the mechanism of a permanently appropriated trust fund, avoiding the uncertainties of annual appropriations.

7. The program's fiscal operations should rest on prospective annual budgets for the support and compensation of providers of medical care

services and goods, in order to bulwark planning and to contain costs within levels determined by national decisions.

8. To assure the worth of services supported by public funds, the design of the program should provide for standards of quality, and the administration should be required to implement all practical measures for the observance of such standards.

9. Administration of the program should involve not only the public authority but also the authoritative participation of representatives of consumers as well as providers of services.

10. There should be mandatory provisions for public accounting of program operations and performances.

It is obvious that the federal government would have an important role to play in the development of a national policy and design for health care. Any effort to solve the health care crisis in our country without massive involvement of government at the federal level would be doomed to failure. We can no longer afford the luxury of thinking that the private sector can take this responsibility alone. But there are still some who are fighting the prospect of further federal intervention into the health care system. As professionals in the health care field, we tend to be more concerned about the exercise of control that the federal government may play in such an undertaking and less concerned about the provision of adequate health care to the citizens of this country regardless of their financial status or their station in life. Programs designed for the benefit of the providers will never move us to the concept of health as a right rather than a privilege. Our consideration for the financing of national health programs should always be undertaken with the consumer as the principal component of whatever health care system is designed. It is also critical

that the delivery of health services and the many changes needed for it to be effective become the central focus of any national health care policy and design. We must, therefore, move away from the eighteenth century health care design to a twentieth century design that will have the federal government as a principal, active partner.

To get some feel for the positive things that can happen to health efforts involving the federal government, let us review briefly the impact of Medicare.

1. There has been a remarkable degree of public acceptance. The level of enrollment in Part B (Voluntary Insurance) is at 94 percent of those eligible.

2. The overwhelming demands on hospitals and physicians, which were feared by many, have not materialized.

3. Federal expenditures under Medicare were large enough to contribute to a significant upward shift in the public share of expenditures for personal health care.

4. Quality of health care in general may improve as a result of Medicare.

5. The program has encouraged hospitals to expand their extramural services to embrace extended care, home health services, and outpatient care.

6. It is expected to act as a powerful spur to the upgrading of nursing homes.

7. It has provided an opportunity for official health agencies to engage in planning, coordinating, standard setting and educational activities with respect to personal health services.

8. Even though serious problems still remain, Medicare has been a major instrument in reducing racial discrimination in hospitals.

I do not wish to imply that all is well relative to this important national program, but it is a fact that if we have the will to succeed in these kinds of efforts, we can dispel the rantings and ravings of the prophets of doom. The same can and must apply in a broader health care context.

Implications for the Role of Two-Year Colleges

It has been the purpose of this discussion to highlight the crisis that we have in health care in this country and to pinpoint the undeniable fact that in order to meet this crisis we need to mount a national effort of some magnitude. We are moving to the point of developing a national policy and a national design for health care. We are still in a fluid state, and it is within this context that two-year colleges should plan and implement the best possible manpower development programs. The implications for the role of two-year colleges are many, and five are suggested for your consideration.

You must maintain a degree of flexibility that will allow you to make the necessary changes in your program as we move toward the development of a national policy and design. It would be disastrous to become locked into certain kinds of educational programs when within the next five years you will be called upon to prepare individuals to go into health fields which do not even exist today and which we cannot even conceive of within our present framework. I realize the difficulties involved in maintaining this kind of flexibility in institutions of higher education. We must, however, find the way to provide the kinds of training programs that are needed today with the understanding that within a few years these programs can be obsolete. In the vernacular of everyday life, we must somehow manage to "stay loose."

Another factor that is of primary importance is the relationship of manpower development to other health care issues. In a twentieth century health care system, the development of manpower for that system cannot be isolated from the many other components and issues. For example, two-year colleges must move forcibly into the political arena pertaining to health care. It is within this context that the health care issues of our time are being discussed and debated; and two-year colleges must be a part of these discussions and debates if you want to have a hand in developing your distinctive role within the health care system, rather than having these roles designated for you by someone else. For too long now, institutions of higher education have been going their own way preparing people to go into the health care field without any active involvement with the other issues and components in that field. This, of course, contributes to the notion of a nonsystem and as such, institutions of higher education must share the blame for the state of affairs in the health area.

In line with this, I see the need for two-year colleges to place considerable emphasis on delivery of care at the local level. You have developed over the years a special relationship with the communities in which you are located; you represent the one component of a higher education system which is closest to the local community and which has developed constituencies within these communities. Therefore, the delivery of health care at that level should be of prime concern to you, and manpower development programs should reach outward to involve the local community. Of all the problems we face, this to me is the most critical -- that of making sure that adequate health care is delivered or provided to individuals when they need it. Higher education institutions in the health field can no longer be the self-contained entities that they have been in the past. They must be active partners in the delivery of health care, and two-year colleges can provide the leadership for such delivery mechanisms in local neighborhoods and communities. Through faculty and student involvement in the planning and delivery of health

care at the local level, they can begin to make a tremendous impact not only on the health care system, but also on improving the health of all citizens.

This leads to a fourth consideration, that of two-year colleges developing partnerships with consumers. In this outward thrust, they need to involve consumers as equal and active partners in the development of educational programs and in the planning and implementation of health care service programs. The times are demanding this; legislation is making it imperative; and consumers are adamant in their statements that they are no longer passive vessels within which we may pour our own notions of health information. They are asserting that they should be active partners in the decision-making process relative to all of the many components that affect their daily living, including the development of health manpower. The consumers of health service can bring to this partnership a vast array of knowledge and skills which if used properly would make a significant impact in establishing and putting into practice an adequate and valid health policy and health care design. Of considerable importance would be the fact that as two-year colleges, you would be in contact with the most important component of a newly developing health care system.

Finally, I would emphasize for your consideration that individually and collectively, you participate as an active partner in influencing the development of a national policy and design for health care. You cannot afford to sit on the sidelines and wait for others to develop the system and them expect to be a vital and integral part of that system. Further, with your years of experience in the development of health manpower, you can make a significant contribution to the development of a national health care system.

In summary, we are now at a point where we must deal effectively with the health care crisis if we are to meet the needs of our population as we move toward the end of this century and into the twenty-first century. To do this, it is mandatory that we, in fact,

have what can be called a national health care system. It is clear that we are in a fluid state and are moving in that direction. Two-year colleges have a major role to play in the events of today, so that we can reach our goals tomorrow. By being flexible so that changes can be made in terms of manpower development, but being certain that they relate these developments to other issues and concentrate on the important phase of the delivery of care at the local level with consumers as their active partners, two-year colleges can be instrumental in influencing the development of national health care policies and design. You are in a unique position to meet this challenge.

LICENSING AND CERTIFICATION OF HEALTH SERVICES PERSONNEL

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I am pleased to be with you this evening to discuss licensing and certification of health manpower and its implication for the planning and operation of health services. I understand that many in tonight's audience are faculty members of two-year colleges in Pennsylvania. You obviously know much about the situation in your own state. My presentation will focus on activities at the national level that relate to credentialing health services personnel.

Credentialing of competent individuals takes the form of certification of qualified personnel by the profession, and/or licensure by a government agency. State laws may provide procedures for licensing, registration, or certification of individuals, with the legislation usually establishing educational qualifications and other requirements. Professional associations may have procedures for certification or registration of individuals, or membership in the association may be sufficient. In either case the applicant must meet certain educational qualifications.

Thus for an individual to be recognized as "qualified" nearly always involves successful completion of an accredited or approved educational program. Another speaker will discuss the topic of accreditation, so I'll proceed with the other two aspects, namely, licensure and certification.

Licensure of Health Occupations

Legislation usually establishes educational, experience, and personal qualifications. It requires successful completion of an examination and provides for issuance of a license as a prior condition for entrance into the occupation. The administration of the statute is entrusted to a department of government or to an independent board. The board is composed of members of the occupation who have been selected from lists of nominees submitted by the associations representing the occupation.

The main objectives of licensing laws are to control the entry into the occupation and to support and enforce standards of practice among licensed practitioners. The accomplishment of these objectives often involves such activities as:

1. examination of applicants' credentials to determine whether their education, experience, and moral fitness meet statutory or administrative requirements

2. investigation of schools to determine whether the training programs meet requisite standards

3. administration of examinations to test the academic and practical qualifications of applicants, to determine if present standards are met

4. granting of licenses on the basis of reciprocity or endorsement to applicants from other states or foreign countries

5. issuance of regulations establishing professional standards of practice; investigation of charges of violation of standards established by statutes or regulations; suspension or revocation of violators' licenses; and restoration of licenses after a period of suspension or further investigation

6. collection of various types of fees

Occupations Licensed by Each State

All States and the District of Columbia require that the following health personnel have a license to practice: dental hygienists, dentists, engineers (including those in environmental control), nurses (both professional and practical), optometrists, pharmacists, physical therapists, physicians (medical and osteopathic), podiatrists, and veterinarians. In addition to these twelve health professions, there are at least twenty others for which one or more states require licensure.[1]

The number of health occupations licensed by a single state ranges from fourteen to twenty-four. California, Connecticut, Florida, Hawaii, Illinois, Nevada, New Jersey, South Carolina and Virginia lead with at least twenty licensed occupations. Alaska, Iowa, Missouri, and Vermont have relatively few.

Trends in Occupational Licensing

Statewide regulation of medical practice was established prior to 1800 in many of the states then in existence in this country. Local and state medical societies were concerned about the training and conduct of practitioners and appealed to the state for legal control over the increasing numbers in the profession. They enforced standards early in the nineteenth century and then relaxed their endeavors.

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[1] Administrators of health departments, hospitals, or nursing homes; chiropractors, clinical laboratory directors or technologists, dental laboratory technicians, inhalation therapists, midwives, naturopaths, opticians and optical technicians; physical therapy assistants, physician assistants, psychiatric attendants, psychologists, x-ray technicians, sanitarians and sanitarian technicians, and social workers.

By the middle of the nineteeth century, standards of professional competence needed to be reformed. At that time the authority to examine and license was largely withdrawn from the medical societies. States began to assume responsibility for regulating the professions as a means of affording greater protection to the public.

Professional groups started organizing into associations at the national level just prior to the Civil War. Among the first were the American Medical Association, founded in 1847; the American Pharmaceutical Association in 1852; the American Dental Association in 1859; and the American Veterinary Medical Association in 1863. These groups urged licensure legislation in the various states, with formal requirements for admission to the profession written into each state law. Thus the professional organizations established a high degree of control over themselves and over the colleges and universities engaged in training for their professions.

The increased emphasis placed on functional specialization by professional schools in the first decade of this century and a desire for occupational identification led several occupations to seek self government. As each of these occupations developed, they requested a separate licensing statute and board.

Because the early laws had originated at a time when there were few health manpower categories, the statutory definition of the practice of medicine was so broad as to include all personal health functions. Legal recognition of the categories that developed later necessitated the carving out of limited exceptions to the broad medical practice acts. Under the present licensing system, the physician has an unlimited license, while other licensed health personnel have limited licenses to perform specific tasks which had formerly been the exclusive province of physicians.

Licensed occupations now include several that have entered the licensing arena only within the past five years. Among these are dental laboratory technician,

inhalation therapist, optical technician, physical therapy assistant, psychiatric attendant, and radiologic technologist. A 1969 statute requires the licensing of Child Health Associates in Colorado. In at least eleven states, statutes authorize delegation of functions to be performed by assistants under supervision of a physician.

Compulsory Versus Voluntary Acts

The nature of the licensing statute may be compulsory (also known as mandatory) or voluntary (permissive). The tendency has been to move from voluntary toward compulsory licensing. Medical practice legislation is typical of the compulsory licensing statute, embodying the principle that no person may practice the profession unless he has complied with certain conditions and then applied for and received a license. Unlicensed persons are prohibited from working in the field. Typical of the voluntary statute is the provision for the optional registration of practical nurses. In almost half the states a person may make himself available for employment as a practical nurse as long as he does not use the title "licensed practical nurse."

Exclusions and exceptions from licensure requirements are always made for Federal employees in the course of their employment and frequently for state and municipal workers. Personnel engaged in research or educational pursuits are sometimes excluded, as are students and auxiliary personnel working under the supervision of a licensed practitioner.

Organizational Patterns

A few state departments license health occupations directly. Where there are boards attached to the department, they may be largely advisory in nature or they may possess broad powers. Many of the boards function independently, with the department providing only administrative assistance.

Some states have taken steps to centralize the licensing of occupations within a single department.

This may be the department of registration, health, state or education.

Many state boards are composed of representatives of direct interest in areas represented by the boards. Very few include representatives of the informed public. About half of the boards require that all board members be licensed practitioners in the occupations regulated by the boards on which they serve. Faculty members of professional educational institutions are rarely specifically included. A few occupations are licensed by boards which include no members of the particular occupation but include members from related occupations.

The boards that license doctors of medicine usually license some related professions. At that time they may have additional representatives of these healing arts serving on the board.

Licensing laws or regulations provide for payment of various fees to finance the board's operations. Applicants may have to pay fees when they submit their original applications for licenses, when they take examinations, when licenses are issued, and when they are renewed.

Most statutes indicate that licenses must be renewed or licentiates must register at stated intervals. About three-fourths of the total occupations licensed in the health field are required to have annual renewal. Usually the only information required for renewal is the current name and address of the practitioner. Little recognition is given to the upgrading of a person's initial qualifications by a program of continuing education.

Qualification for Initial Licensure

Applicants for initial occupational licenses may have to meet four different types of qualifications -- personal, education, experience, and examination.

Personal qualifications that are often specified relate to minimum age (such as 21 years), good moral

character, good health, U.S. citizenship (or declaration of intent), and a minimum period of residence (or training) in the state.

Educational qualifications place emphasis on formal education as a necessary prerequisite for licensure. Applicants must fulfill the specified minimum period of education in approved schools or programs. Some licensing boards set their own standards for approval, while others accept standards established by the profession or by official educational agencies. Few licensing statutes contain provisions permitting boards to accept alternates or equivalents in place of specified educational requirements.

In addition to formal educational requirements, applicants may have to fultill certain experience requirements in form of internship, clinical work as part of the educational program, supervised practice or apprenticeship. Many licensing statutes provide alternate combinations of education and experience requirements.

Applicants who meet the personal, education, and experience requirements become eligible to be examined. Such examinations may be written, oral, practical, or a combination of these types. Written examinations are usually required for occupations in the health field. The board may use all or part of a national examination, or it may choose to accept a certificate from a national board of examiners.

Another method of entry is under the "grandfather clause" or waiver. These provisions are included in the law to cover the individuals in practice when the law was passed. All or part of the education and examination requirements may be waived for a specified period of time.

Certification of Qualified Health Personnel

Enough on licensure. Let's turn our attention now to the certification process. The process of recognizing

the competence of practitioners by voluntary associations may take the form of association membership, registration, certification, or a combination of the three.

Association Membership

Some of the professional associations in the allied health field date back half a century. The American Dietetic Association and the American Occupational Therapy Association were established prior to 1920. The 1920s saw the establishment of the American Medical Record Association, American Physical Therapy Association, American Dental Assistants Association, American Dental Hygienists Association, and American Society of Radiologic Technologists. In the 30s and 40s came more, until the number of associations almost equals the number of health occupations.

To become a member of a professional association implies having met certain standards for admission. These requirements include qualifications of education, experience, or both. They are aimed at including the qualified, but, at the same time, they have the effect of limiting competition in the work force. Many professional associations have the basic requirement of graduation from an AMA-approved program in the specific field. An additional requirement for membership may be registration or certification by a nongovernment agency, which implies a period of supervised experience and successful completion of the registry examination.

A few of the associations accept members qualified at both the baccalaureate-or-higher level and at the associate degree level. On the other hand, some of the emerging or new occupations are not accepted as members in the professional associations in their fields, nor are they strong enough in numbers to form separate associations.

Association membership may represent nearly all persons employed in the specific health field. Persons who could qualify for membership may not choose to belong

for various reasons, while others working in the field do not have the qualifications essential for membership.

Certification and Registration

For some professions there are committees, boards, or registries concerned with distinguishing quality of personnel. The certifying or registering function may be within the professional association as in the case of dental assistants, dietitians, medical record librarians*, and occupational therapists. Other agencies may be set up independent of, but obviously related to, the profession being controlled; examples are the Board of Registry of Medical Technologists of the American Society of Clinical Pathologists, American Registry of Inhalation Therapists (sponsored by physicians and inhalation therapists), and American Registry of Radiologic Technologists (sponsored by physicians and radiologic technologists).

Persons who meet certain requirements of education, experience, and competency and who successfully complete the examination given by the certifying agency may use special professional designations. Examples of these designations include RRL for Registered Record Librarian,* MT(ASCP) for Registered Medical Technologist, O.T.R. for Registered Occupational Therapist, and C.O.T.A. for Certified Occupational Therapy Assistant.

Applicants for certification are nearly always required to pass a written examination given by the registry. The proportion that pass varies considerably from one field to another. For example, at least ninety percent of the dietitians, medical record librarians,* and medical record technicians who took registry examinations last year were successful: in contrast only about 70 percent of the radiologic technologist candidates passed. (These examination results include persons taking the test for the first time, and those repeating for the second time or more.) The passing point on the curve is usually

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*Title changed October 1971 from librarian to administrator.

determined in relation to first-timers and is set each time by the agency administering the examination to permit only a certain proportion (usually between 70 and 90 percent) to pass. The written examination may be accompanied by a practical examination of technical skills, as in the case of dental assistants and technicians.

Membership in the professional association is another standard for certification. When the registry is a part of the professional association, it is usual to require that the applicant be a member of the association at the time of the registry examination. When the registry is a separate agency--even though the professional association is one of its sponsors--membership in the association may not be necessary.

Education and experience together make up the third standard for certification. Graduation from an approved program in the specific subject matter is a "must" in almost all cases. Only recently has there been recognition of an equivalent to such education for persons who gained their knowledge through non-traditional study.

It is the usual practice in establishing the initial registry, and for a specified time thereafter, to "blanket in" experienced persons who may have lesser education than the current standard. Thus competence in actual practice is substituted for formal training, since the grandfather clause permits registration without taking the written examination.

One feature of the registry of dietitians that is noteworthy is the continuing education requirement which must be met every five years for a member's registration to remain in effect. Two dental occupations--assistant and technician--require evidence of continuing education for renewal of certification. Few other health professions profess the objective of maintaining or increasing the competency of the practitioner after initial registration.

Implications for Health Manpower

The credentialing of health personnel has an obvious direct bearing on the planning and operation of health services. Certification and licensure relate to the supply of manpower by controlling entrance into practice. They relate to the stability of the labor force by effecting mobility and thus retention of workers. And, last but not least, they relate to the quality of personnel by providing standards for measurement of competence.

You are well aware of the manpower problems that have developed in recent years with increased public demands for health services. We talk in terms of almost four million health workers at the present time. Nearly half this number are in occupations for which the appropriate requirement for basic occupational preparation is less than the baccalaureate level. Included are technicians and assistants allied to medicine and dentistry, environmental health workers, and nursing auxiliaries. For each ten such workers, we are presently short one additional person to meet current manpower requirements.

National health insurance is now visible on the horizon. What will be the impact on the numbers and kinds of health personnel needed to provide the services implied by this major program?

To meet the need when it comes will require significant changes in education and employment practices. Some solutions lie in the development and implementation of education equivalency and work proficiency examinations, along with the more efficient organization of educational programs. Better utilization and retention of manpower already employed will depend largely upon the success of efforts to enhance career mobility by removing artifical barriers to advancement. The assumption by allied health personnel of more responsible and difficult duties would go a long way toward producing enough qualified manpower. Since credentialing practices serve as screening devices,

they must be channeled to encourage every opportunity for health workers.

Standards for qualifying health practitioners should be developed to provide common goals and permit geographic mobility across the nation. The standards should allow maximum degree of movement within and between professions or disciplines, with appropriate minimum qualifications for entry. And lastly, measurement of competence to meet these standards must be developed and incorporated into the credentialing process--be it accreditation of educational programs, certification of qualified personnel by the profession, or licensure of individuals by a government agency.

GLOSSARY

Accreditation is the process by which an agency or an organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. Accreditation shall apply only to institutions and programs.

Certification is the process by which a non-governmental agency or an association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

Challenge Examination is equivalency testing which leads to academic credit or advanced standing in lieu of course enrollment by candidate.

Credentialing is the recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, professional association membership, or the award of a degree in the field.

Equivalency Testing is the comprehensive evaluation of knowledge acquired through alternate learning experience as a substitute for established educational requirements.

Licensure is the process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation, to use a particular title, or both, or grants permission to institutions to perform specified functions.

Proficiency Testing assesses technical knowledge and skills related to the performance requirements of a specific job; such knowledge and skills may have been acquired through formal or informal means.

Qualifying Examination is a criterion for measuring an individual's ability to meet a predetermined standard.

Registration is the process by which qualified individuals are listed on an official roster maintained by a governmental or non-governmental agency.

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TABLE A

List of Associations Recognized for Their
Specialized Accreditation of
Health Educational Programs, 1970

ALLIED MEDICAL HEALTH EDUCATION
(medical laboratory technician education)
Accrediting Bureau of Medical Laboratory Schools
Hugh A. Woosley, Administrator
3038 West Lexington Avenue, Elkhart, Indiana 46154

(programs for medical technologist, occupational therapist, physical therapist, medical record librarian, medical record technician, and radiologic technologist-technician)

American Medical Association, Council on Medical Education
C.H. William Ruhe, Secretary
535 North Dearborn Street, Chicago, Illinois 60610

DENTISTRY
(programs leading to DDS or DMD degrees, and programs for dental hygienist, dental assistant, and dental laboratory technician)
American Dental Association
John M. Coady, Secretary
Council on Dental Education
211 East Chicago Avenue, Chicago, Illinois 60611

HOSPITAL ADMINISTRATION
(graduate degree programs)
Accrediting Commission on Graduate Programs in Hospital Administration
L. Filerman, Executive Director
One Dupont Circle N.W., Suite 420 Washington, D.C. 20036

MEDICINE

(programs leading to M.D. degree)

Liaison Committee on Medical Education representing the Council on Medical Education, AMA, and the Executive Council, AAMC

(In even-numbered years)
C.H. William Ruhe, Secretary
Council on Medical Education
American Medical Association
535 North Dearborn Street, Chicago, Illinois 60610

(In odd-numbered years)
John A.D. Cooper, President
Association of American Medical Colleges
One Dupont Circle, N.W.; Suite 200,
Washington, D.C. 20036

NURSE ANESTHESIA

(professional schools)

American Association of Nurse Anesthetists
Bernice O. Baum, Executive Director
111 East Wacker Drive, Chicago, Illinois 60601

NURSING

(professional, technical, and practical nurse programs)

National League for Nursing, Inc.
Margaret E. Walsh, General Director and Secretary
10 Columbus Circle, New York, New York 10019

(practical nurse programs)

National Association for Practical Nurse Education and Service, Inc.
Rose G. Martin, Executive Director
1465 Broadway, New York, New York 10036

OPTOMETRY

(professional schools)

American Optometric Association
Charles G. Lile, Executive Secretary
Council on Optometric Education
7000 Chippewa Street, St. Louis, Missouri 63119

OSTEOPATHIC MEDICINE
(programs leading to D.O. degree)
American Osteopathic Association
Lawrence W. Mills, Director
Office of Education
212 East Ohio Street, Chicago, Illinois 60611

PHARMACY
(professional schools)
American Council on Pharmaceutical Education
Fred T. Mahaffey, Secretary
77 West Washington Street, Chicago, Illinois 60602

PODIATRY
(baccalaureate and professional programs)
American Podiatry Association
John L. Bennett, Director
Council on Podiatry Education
20 Chevy Chase Circle, N.W., Washington, D.C. 20015

PSYCHOLOGY
(doctoral programs in clinical and counseling psychology)
American Psychological Association
Ronald B. Kurz, Associate Educational Affairs Officer
1200 17th Street, N.W., Washington, D.C. 20036

PUBLIC HEALTH
(master's degree programs in community health education and graduate professional schools of public health)
American Public Health Association, Inc.
Director of Professional Education
1015 18th Street, N.W., Washington, D.C. 20036

SOCIAL WORK
(graduate professional schools)
Council on Social Work Education
Frank M. Loewenberg, Director
Division of Educational Standards and Accreditations
345 East 46th Street, New York, New York 10017

SPEECH PATHOLOGY AND AUDIOLOGY
(master's degree programs)
American Speech and Hearing Association
Stanley Ainsworth, Chairman
Education and Training Board
9030 Old George town Road, Washington, D.C. 20014

VETERINARY MEDICINE
(professional programs leading to DVM or VMD degrees)
American Veterinary Medical Association
W.M. Decker, Director of Scientific Activities
600 South Michigan Avenue, Chicago, Illinois 60605

Source: U.S. Department of Health, Education, and Welfare; Office of Education, Bureau of Higher Education, Accreditation and Institutional Eligibility Staff. Nationally Recognized Accrediting Agencies and Association... (Washington, D.C.: Government Printing Office, March, 1971).

TABLE B

Designation of Certification or Registration of Health Manpower
by Nongovernment Agencies, 1970

Health Field and Occupation	Designation	Agency
CLINICAL LABORATORY SERVICES		
Clinical Chemist	Diplomate	American Board of Clinical Chemistry
Microbiologist	"	American Board of Microbiology
Medical Technologist 1/	M.T.	American Medical Technologists
	MT (ASCP)	Board of Registry of Medical Technologists of the American Society of Clinical Pathologists
Cytotechnologist	CT (ASCP)	"
Histologic Technician	HT (ASCP)	"
Certified Laboratory Assistant	CLA (ASCP)	"
Medical Laboratory Technician	MLT (ASCP)	"
DENTISTRY AND ALLIED SERVICES		
Dentist	Diplomate	8 specialty boards recognized by American Dental Association
Certified Dental Assistant	C.D.A.	American Dental Assistants Association Certifying Board
Certified Dental Technician	C.D.T.	National Board for Certification in Dental Laboratory Technology
DIETETIC AND NUTRITIONAL SERVICES		
Registered Dietitian	R.D.	American Dietetic Association
ENVIRONMENTAL CONTROL		
Environmental Engineer 2/	Diplomate	American Academy of Environmental Engineers
Sanitarian	"	American Intersociety Academy for Certification of Sanitarians
Health Physicist	"	American Board of Health Physics
Industrial Hygienist	"	American Academy of Industrial Hygiene
LIBRARY SERVICES		
Medical Librarian 3/	Certified	Medical Library Association
MEDICAL RECORDS		
Registered Record Librarian 4/	RRL 4/	American Medical Record Association
Accredited Record Technician	ART	"

Health Field and Occupation	Designation	Agency
MEDICINE AND OSTEOPATHIC MEDICINE		
Physician	Diplomate	20 specialty boards recognized by American Medical Association
Osteopathic Physician	"	12 specialty boards recognized by American Osteopathic Association
OCCUPATIONAL THERAPY		
Registered Occupational Therapist	O.T.R.	American Occupational Therapy Association
Certified Occupational Therapy Assistant 3/	C.O.T.A.	"
OPTOMETRY, OPTICIANRY, AND OTHER OCULAR SERVICES 5/		
Orthoptist	Certified	American Orthoptic Council
ORTHOTIC AND PROSTHETIC TECHNOLOGY		
Orthotist	Diplomate	American Board of Certification in Orthotics and Prosthetics
Prosthetist	"	"
PHYSICAL THERAPY		
Registered Physical Therapist	P.T. (ARPT)	American Registry of Physical Therapists
RADIOLOGIC TECHNOLOGY		
Registered Radiologic Technologist 6/	R.T. (ARRT)	American Registry of Radiologic Technologists
	R.T. (ART)	American Registry of Clinical Radiography Technologists
SECRETARIAL AND OFFICE SERVICES		
Medical Office Assistant	Certified	American Association of Medical Assistants
SOCIAL WORK		
Social Worker 3/	Certified	Academy of Certified Social Workers
SPECIALIZED REHABILITATION SERVICES 7/		
Certified Corrective Therapist	C.C.T.	American Board for Certification of Corrective Therapists
Registered Music Therapist 3/	R.M.T.	National Association for Music Therapy

Health Field and Occupation	Designation	Agency
SPEECH PATHOLOGY AND AUDIOLOGY		
Speech Pathologist	Certified	American Speech and Hearing Association
Audiologist	"	"
VETERINARY MEDICINE		
Veterinarian	Diplomate	7 specialty boards recognized by American Veterinary Medical Association
MISCELLANEOUS HEALTH SERVICES		
Registered Inhalation Therapist	A.R.I.T.	American Registry of Inhalation Therapists
Certified Inhalation Therapy Technician	Certified	American Association for Inhalation Therapy Certification Board
Registered Electroencephalographic Technologist	R. EEG T.	American Board of Registration of Electroencephalographic Technologists
Certified Operating Room Technician	C.O.R.T.	Association of Operating Room Technicians Certification Board

1/ Specialty certification as technologists in blood banking, chemistry, microbiology, and nuclear medicine. See also National Registry in Clinical Chemistry and National Registry of Microbiologists.
2/ Four subspecialties: air pollution control, industrial hygiene, radiation and hazard control, and sanitary engineering.
3/ No certifying examination required.
4/ Title changed October 1971 from librarian to administrator: RRL to RRA.
5/ For ophthalmic assistant the American Registry of Ophthalmic Medical Assistants is more like a professional society than a true registry.
6/ Specialty certification as technologists in diagnostic radiology, nuclear medicine, and radiation therapy.
7/ For recreation therapist the National Therapeutic Recreation Society maintains a "registry" of persons so employed.

Source: M.Y. Pennell, J.R. Proffitt, and T.D. Hatch. *Accreditation and Certification in Relation to Allied Health Manpower*, U.S. Department of Health, Education, and Welfare; National Institutes of Health, Publication No. (NIH) 71-192 (Washington, D.C.: Government Printing Office, 1971).

TABLE C

Health Occupations Licensed in Each State, 1971

State	Number of occupations licensed[1]	Clinical laboratory personnel																		
		Administrator[2] of nursing home	Chiropractor	Director	Medical technologist	Dental laboratory technician	Inhalation therapist	Midwife	Naturopath	Optician	Optical technician	Physical therapy assistant	Physician assistant	Psychiatric attendant	Psychologist	Radiologic technologist	Sanitarian	Sanitarian technician	Social worker
Total.....	893	49	49	13	10	1	1	23	8	17	2	11	1	3	43	3	35	1	9
Ala.....	18	x	x		x							x	(4)		x				
Alaska....	14		x												x		x		
Ariz.....	18		x					(3)	x	x		x	(4)		x				
Ark.....	18	x	x				x						(4)	x	x		x		
Calif.....	24	x	x	x	x			(3)	(3)	x[5]			(4)	x	x	x	x		x
Colo.....	18	x	x					(3)					x		x		x		
Conn.....	21	x	x	x				(3)	x	x	x				x		x		
Del.....	17	x	x	x				x							x				
D.C.....	16	x	x					x							x				
Fla.....	22	x	x	x	x			x	(3)	x		x	(4)		x		x		
Ga.....	18	x	x					x		x					x		x		
Hawaii....	21	x	x	x	x			x	x	x					x		x		
Idaho.....	16	x	x										(4)		x		x		
Ill.....	20	x	x	x	x			(3)							x		x		x
Ind.....	17	x	x					x							x		x		
Iowa.....	14	x	x																
Kans.....	15	x	x										(4)		x				
Ky.....	19	x	x					x		x		x			x		x		
La.....	16	x						x							x		x		
Maine.....	16	x	x												x				x
Md.....	19	x	x	x	x			x							x		x		
Mass.....	16	x	x							x							x		
Mich.....	17	x	x											x	x		x		
Minn.....	17	x[2]	x					x							x				
Miss.....	15	x													x		x		
Mo.....	14	x	x																
Mont.....	15	x	x														x		
Nebr.....	16	x	x												x		x		
Nev.....	20	x	x	x	x					x		x			x		x		
N.H.....	15	x	x												x				
N.J.....	23	x[2]	x	x	x			x		x	x				x	x	x		
N.Mex.....	17	x	x					x							x		x		
N.Y.....	19	x	x	x						x			(4)		x	x			x
N.C.....	19	x	x					x		x					x		x		
N.Dak.....	15	x	x												x				
Ohio.....	15	x	x					x											
Okla.....	18	x	x									x	(4)		x		x		x

TABLE C (CONT.)

State	Number of occupations licensed[1]	Administrator[2] of nursing home	Clinical laboratory personnel: Chiropractor	Director	Medical technologist	Dental laboratory technician	Inhalation therapist	Midwife	Naturopath	Optician	Optical technician	Physical therapy assistant	Physician assistant	Psychiatric attendant	Psychologist	Radiologic technologist	Sanitarian	Sanitarian technicial	Social Worker
Total.....	893	49	49	13	10	1	1	23	8	17	2	11	1	3	43	3	35	1	9
Oreg.....	18	x	x						x			x			x		x		
Pa.....	16	x	x	x	x														
R.I.....	19	x	x	x						x					x		x		x
S.C.....	21	x	x			x				x		x			x		x	x	x
S.Dak.....	15	x	x														x		
Tenn.....	19	x	x	x	x					x					x		x		
Tex.....	17	x	x									x			x		x		
Utah.....	18	x	x						x				(4)		x		x		x
Vt.....	14	x	x																
Va.....	20	x	x					x		x		x			x		x		x
Wash.....	19	x	x					x	x	x			(4)		x		x		
W.Va.....	17	x	x					x							x		x		
Wis.....	16	x	x												x		x		
Wyo.....	16	x	x					x							x				

[1]For the following 12 professions a license is required to practice in all States and the District of Columbia: Dental hygienist, dentist, engineer (professional), nurse (practical), nurse (professional), optometrist, pharmacist, physical therapist, physician (M.D.), physican (D.O.), podiatrist, and veterinarian.

[2]Also health department administrator in New Jersey and hospital administrator in Minnesota.

[3]New licenses are no longer issued although those in existence may be renewed.

[4]Statutes authorize delegation of functions to be performed under supervision of a physician.

[5]Owner or manager of optical company required to be licensed.

Source: M.Y. Pennell, and P.A. Stewart. State licensing of Health Occupations. Public Health Service Pub. No. 1758. U.S. Department of Health, Education and Welfare; National Center for Health Statistics. Washington, Government Printing Office, 1968, pp. 4-5.

M.Y. Pennell, J.R. Proffit, and T.D. Hatch. *Accreditation and Certification in Relation to Allied Health Manpower.* Pub. No. (NIH) 71-192. U.S. Department Health, Education, and Welfare; National Institutes of Health (Washington, D.C.: Government Printing Office, 1971), pp. 38-39. Updated.

LICENSING AND CERTIFICATION: ANOTHER VIEW

Douglas A. Whyte, Coordinator
Department of Human Service Careers
Community College of Philadelphia

As I understand it, I am here to react to Mrs. Pennell's scholarly paper from the social side of the "house." The experience upon which I will base my discussion is the directing of and teaching in the Mental Health Work Curriculum and Social Service Curriculum at Community College of Philadelphia.

My bias, based on personal experience and thinking, reading, and discussion with others in the field, is that certification and licensing does not work in this field. My main thrusts which follow will be two. First, what a human service worker needs to know and be, how he develops; and why this throws a "monkey wrench" into the certification and licensing "works." I will then follow up with some thoughts about alternative plans.

The view which follows of what a human service worker needs to be is a personal one. However, it is probably one that many in the field would share. There are a number of areas where a human service worker needs to know certain information and have certain abilities. The graduate of an A.A. program in human service needs to know a certain body of theory. He must have some sensitivity to other people. He has to be open as a human being -- by this I mean able to share with others, for purposes of professional training, his successes and failures. Dr. Combs has said that a helper must be aware of his real, unspoken, but non-verbally expressed attitudes and values. The graduate must be comfortable with responsibility. He must be willing to make a commitment to people. He needs to have skills in working with individuals and groups. He should be comfortable dealing with feelings. He should be able to use supervision. Finally, he must have a knowledge of himself as a developing helper and approximately where he is in his development.

By looking at this list, you begin to see the problems inherent in determining a person's competence in these areas. Now let me compound the problem. Students come to us with all levels of maturity and experience. The seventeen-year old just out of high school; the mid-twenty's, early-thirty's person who has been a secretary, technician, etc.; and the fifty-year old woman who is re-entering the labor force now that her children are grown are three very different groups of people. And there are substantial differences within the groups. They all enter the same curriculum and what happens? First, they are challenged at differing levels. In a curriculum such as this, the practicum class really has to be repetitive. Each semester you cover basically the same material, increasing in depth. You know that students will pick up pieces and use them as they are ready to do this. Therefore, in any one group you will find many levels of understanding.

Now, with all this as a background, what can we expect of the graduate? We can expect, I think, a beginning in all of the areas I mentioned and more than a beginning in some of them. Some of our graduates are just barely getting out our door. Others are capable of working with the best in the field. (In fact, the B.A. programs are basically redundant for our graduates--they do what we do in the students' junior and senior years.) How do you certify them? I do not think you do.

So where do we go from here? Let me suggest two ideas. At West Philadelphia Consortium for Mental Health/Mental Retardation, Jim Green determines the differential use of staff by having a case presented to the staff and allowing the staff (which ranges in education) to determine who picks up the case. They do this by individuals expressing their feelings of competence (or lack of) to deal with that situation. His only problem with this approach is that the staff often undervalues itself. A second approach which has been suggested is a supermarket one. The client starts with Brand X (Mr. Jones) and if he is unahppy with Brand X he can switch to Brand Y (Miss Brown). Helpers would be used differentially by the clients having an input into the use of staff by whom they choose and stay with. Part

of this is a redundancy of services--you provide for more staff than your service population needs. Otherwise, when the client wanted to switch brands, no other helper would be available.

The point is the ability to help--competence--varies tremendously regardless of the degree a person may have. Therefore, we need a way to utilize and pay staff on the basis of their ability. Further, we can expect ability to increase with experience, supervision, in-service training, and through participation in institutes and specialized educational programs. There is a need for specialized, short-term educational programs in such areas as specific therapies, community change, social policy, etc. which developing staff can plug into. We also need changes in the employing agencies. I think this is beginning. The fact which Dr. Sussman pointed out in his address that people without the M.S.W. are doing jobs previously reserved for the profession is frightening to the old-line professions, but they are beginning to deal with it. Finally, the A.A. programs into which these potential helpers go must be topnotch. They must be intensive experiences. To produce the kind of changes necessary, there must be a very personalized kind of instruction.

SEEING IS BELIEVING, PLANNING IS PROJECTING: HUMAN SERVICE PROGRAMS

Martha A. Burns, Coordinator of
Educational Counseling for Adult Students
The Pennsylvania State University

Human Service Programs -- under that umbrella are included so many services we all count on day after day. Recreation, law enforcement, health services, fire prevention protection, child care, social welfare, institutional assistance and education all fall into the broad category of human service. Our main concern is how we, as educators, can help to meet the challenge of the growing need for, and accelerating awareness of, human service. It was this topic which was the subject of my research which was done with Dr. Theodore Kiffer during a two-year period ending in June 1971. By sending out approximately 500 questionnaires to administrators of human service programs in various fields and in different colleges throughout the United States (and by receiving better than 300 completed questionnaires) we were able to compile information about how some human service programs have been initiated, the costs involved in initiating different programs, the source and nature of their students and faculty, and the employment picture for human service program graduates.

As one glances at the title of this discussion, it might be said that "seeing is believing" was my job as a fact-finder; "planning is projecting" becomes your job as you consider the development of new human service programs in light of this and other research.

The facts which emerged from this study do not present one clear-cut picture of the ideal human service occupational education program. Instead, they disclosed a variation in curricular emphasis, a noticeable incongruence between programs in terms of funding, and differences in student clientele. Certain trends could be ferreted out from the data and certain patterns did become evident.

This morning, I will try to give you an overview of the findings of this study of human service programs.

At the outset, it should be mentioned that in compiling this data for the soon-to-be-published *Handbook of Human Service Occupational Education*, one was caught up in the spirit of pioneering, of adaptation, and innovation that marks these programs. They seemed to be a product of a commitment to serving. The survey returns were more often than not replete with extra comments, extended explanation, or supplementary information. Since some of you sitting here helped us in this venture, let me extend my thanks for giving us the facts, and often for more than just the facts.

The Human Service Programs surveyed in this study have been in existence an average of three to four years. Their relative youth made information on initiation concerns highly accessible. In scanning the responses to questions regarding program initiation, one could make several observations:

1. Most programs were sparked by community pressure, particularly the child day care, fire prevention, and health paraprofessional programs; though manpower surveys were given considerable credit for demonstrating the need for programs in education, parks and recreation, and hotel, motel, and food service areas.

2. Advisory committees were appointed in 86 percent of the programs surveyed. These committees were likely to be composed primarily of local professional people, faculty members, and administrators. Students were members of advisory committees in only 13 percent of the programs. In each of the human service areas, the single-most important criterion in selecting advisory committee members was said to be professional interest in the program. Advisory committees generally met only on request, though some had regular annual or semiannual meetings.

3. Local Agencies were usually consulted prior to program initiation (89 percent). However, only 30 percent of the programs received any direct contributions of funds, facilities or faculty from local agencies. Most contributions made were availability of facilities and part-time faculty.

4. Most program directors were hired less than six months before students began attending classes in the program, many were hired less than three months before classes started. The problems in such late appointments were evident in suggestions that "directors need time to establish a community base before students arrive."

Costs

Only 65 percent of schools responding reported costs; however, those program administrators responding to financial questions presented a picture of generalized low costs. Costs for administration, facilities, specialized equipment, and student recruitment were said to be $5,000 or less for most human service programs. Faculty costs were more variable. Faculty for hotel, motel and food service programs, law enforcement, and parks and recreation programs ranged from $10,000 to $15,000, though faculty costs in other human service areas were most often said to be under $7,000. The most expensive programs were in the health human service field. (See Table I)

The average expense for faculty for a new medical program would be in the $15,000 - 20,000 range while administrative costs stayed relatively low, averaging $8,000 dollars. Costs for space and equipment for new medical programs were high, averaging $15,000 for facilities and $13,000 for equipment. Special equipment and space for a first health service program do cost a considerable amount of money; however, additional health programs utilizing much of the same space and equipment do cost much less.

TABLE I

Faculty	none	*$5 or less	$5-7	$7-10	$10-15	$15-20	$20-30	$30 or more
All	2	12	8	14	20	7	10	12
Nursing	0	2	1	2	1	2	5	8
Administration								
All	14	16	7	8	12	8	0	2
Nursing	1	3	3	3	5	3	0	1
Space								
All	19	21	4	4	4	2	1	13
Nursing	2	4	1	1	2	1	0	5
Equipment								
All	7	23	5	7	9	6	3	15
Nursing	1	7	2	0	2	2	1	4

*Expressed in thousands of dollars

Some costs for program initiation and implementation were borne by external agencies. Federal, state, and local funds were the most frequent source of external assistance. A noticeable trend was for one program to have federal, state, and local governmental assistance while another program of the same type received no external funds. The reason for this phenomenon was uncertain.

One means of cutting costs for human service programming was to utilize outside facilities such as hospitals, schools, nursing homes, and day care centers. At least 119 human service programs were utilizing these valuable, often rent free, facilities. Many of the people responding to our questionnaires indicated that use of such facilities added a new and valuable dimension to their educational programs.

Faculty

Additional faculty members needed to start human service programs were located or recruited primarily through individual community contacts made by program administrators or adviosry committee members. Approximately half the faculty needed were recruited simply by individual community contacts, while another 30 percent were located and recruited through contacts with local professional groups. Only 17 percent of the respondents indicated public advertisement as the source of faculty.

In many human service programs local practicing professionals are utilized as part-time faculty. Sixty-three respondents indicated that this method of obtaining specialized faculty was currently utilized while forty-nine other responses indicated that the practice of using local professionals as part-time faculty might be desirable in the future.

The single-most important crition for selection of faculty as seen by a vast majority of respondents was

"experience on-the-job in the paraprofessional subject area." A close second was the possession of an advanced degree. The fields which apparently relied most heavily on experience were fire protection, health, and child care.

A faculty member in a human service program would, according to our study, typically teach thirteen to fifteen contact hours per week. A variation between programs was noticeable here. The expectations for faculty ranged from six to thirty contact hours per week of the programs surveyed.

In 72 percent, at least some faculty time would be spent in supervising practicum experiences. In some places (72) this responsibility is shared between college faculty and local agencies, while fourteen programs give full responsibility for practicum supervision to local agency personnel.

Students

Most students enrolled in the human service programs surveyed live within a fifteen-mile radius of the campus where they are enrolled. These, then, as you might expect, are overwhelmingly community-based students. The pattern of the typical student breaks down here, though. The attraction of a mature adult to certain fields such as education, child day care, and fire protection becomes clear. On the other hand, and in direct contrast, most of the students enrolled in health, parks and recreation, and hotel, motel and food services programs are recent high school graduates. Government service, law enforcement, and social work programs seem to attract a widely diverse student body -- approximately half are employed full-time, while the other half are said to be recent high school graduates.

The motivating factors for students to enroll in human service programs present another study in variability. Fire protection programs were said by respondents

to attract highly altruistic students (this, no doubt, is affected by the fact that several programs serve volunteer firemen interested in preparing themselves to serve their communities more effectively). Health and social work also ranked high in terms of altruism of the students. In fact, in each of the nine human service fields, respondents indicated that no less than 50 percent of the students were motivated by altruistic attitudes.

In 80 percent of the human service programs studied, student enrollments increased, while only about 5 percent have decreased, indicating stability in the student population of many of the programs.

Curriculum

Most human service curricula seem to follow these trends: (1) focus on skill, theory, and technique. Slightly more than one-half of most curricula reflect this focus; (2) maintain a prescribed, though not always rigid, liberal arts core, and (3) require a practicum unless the student is employed in the field concurrent with his enrollment in the program. Social work programs are the only ones which seem more heavily general education oriented, while hotel, motel, and food service programs seem more heavily skill, theory, and technique oriented.

Since these human service programs are being utilized by a varied clientele, it was interesting to note that 41 percent of the programs offered both day and evening courses. Nevertheless, the majority of the coursework was geared strictly to the day student (54 percent).

The academic degrees most popular among the human service programs surveyed were the Associate of Arts (69), the Associate of Science (48), the Associate of Applied Arts and Science (48) and the certificate (34). Some programs offered both Associate Degrees and certificates in the same human service field by varying the

length of the program and the general education requirements in the curriculum.

Employment

Since forty-four of the human service programs surveyed had no graduates at the time of the study because they were less than two years old, the data here is sketchy. It would seem that only one clear-cut trend was identifiable -- all administrators or faculty who filled out this part of the questionnaire believed that promotions came easier to graduates of their programs.

Be that as it may, 102 respondents noted the availability of civil service classifications to their graduates. This governmental plan facilititates some employment and is also seen by many as a security device. It also seemed that most graduates could find employment in or near the area in which they had attended school (83 percent). Estimates of starting salaries varied among human service fields with the median expected salary between 6-7,000 dollars per year. Since many students in fire protection, government service, and social work were employed during their participation in the programs, concerns for job placement in these human service categories was minimal.

I trust that these facts and figures will be useful as you contemplate the planning of human service programs. The prospect is that more and more human service programs will be developed to fulfill the human needs of a society in which a greater life expectancy, more leisure time, shorter work days and weeks, and compression into denser population areas is the norm. Human problems will increase, and concurrently human service programs should be developed to help solve those problems.

ACCREDITATION OF HUMAN-HEALTH SERVICE PROGRAMS

B. E. Childers, Executive Secretary
Committee on Occupational Education
Southern Association of Colleges and Schools

It's a pleasure for me to be here. I would bring you greetings from the sunny South except that it was as cold in Atlanta when I left yesterday as it is here in Pennsylvania. As a matter of fact, it was snowing a little there yesterday also, so there is not that much difference between the South and the North.

The program that I am involved with is the field of accreditation. It is a new program; in fact, the Southern Association is the first regional association to work directly with the field of occupational education in developing succinct criteria related to occupational programs. One of the early questions that always arises regarding this relationahip is "Why did you use the term *occupational education* in lieu of *vocational education* or *technical education*?" I don't really know, to tell the truth, because this term was selected before I got there. It seems, however, that *occupational education* does connote a larger segment of the field of education than does the traditional concept of vocational and technical education. This was brought home to me very recently when we got an application from the International Equestrian Institute in Virginia. I realized that most of our criteria were related to the vocational areas and the technical areas, and not the broad spectrum of occupational areas.

We have identified over the years in occupational education some rather succinct definitions regarding certain aspects of education that we assumed everyone else agreed to. We are finding more and more, however, that these definitions and these standard terminologies

that we have assumed for so long, are not widely agreed upon. We spent the past three years working under the publications committee of the American Vocational Association to produce a terminology of definitions in vocational-technical education, and now that it is out, we are chagrined to find that the terms we identified three years ago are no longer commonly used in certain aspects of the program. If you have seen the document, you know exactly what I am talking about.

Terminology is probably one of our biggest problems in the field of education. One segment of the country uses terminology to identify certain characteristics in the field and another section of the country uses another terminology. Approaches to the education process vary, region by region, section by section, state by state, and even locality by locality, in many cases. Now, I don't think this is a bad idea. I think the worst thing that could develop is a federation of education at the national level which would mandate all designations, criteria, and structures regarding education.

One of the strengths of the American education system is that there is diversity in approach to programs. This diversity does lead to some confusion and problems in certain areas, especially in accreditation programs such as ours. We are finding that the approach that we are taking in the South is getting national recognition and acceptance. As little as fifteen years ago, we found it difficult to get two people in the academic community to talk about vocational and technical education. The conversation was always centered around financing, building, new construction, and similar concepts. We find now that when we get educational groups together, almost without exception, people want to talk about the field of occupational training, their major concern and interest. For the first time, we have a commissioner that is directly committed to a concept of career education which includes a heavy emphasis on vocational and technical education. If this program evolves to the point that the commissioner anticipates, there will be a major revision of educational concepts in this country. He is firmly committed to the concept of bringing career

education as a core approach to education in our community schools.

Let's look, then, at the program of accreditation. Last night, you heard a discussion of the concepts of certification, licensure, and accreditation. Now I will present a different approach to the concept of accreditation, or the identity and improvement of quality in education. There are thirty-five specialized agencies recognized by the Commissioner of Education. Dr. Charles Ward of North Carolina State University has done a study on the accreditation of occupational education and identified more than seventy specialized agencies that certify and approve programs in the specialized categories of human services, physical services, as well as health services. The certification structure of specialized accrediting agencies has both an accreditation program and a licensure and certification program. The former is a volunteer structure by a professional organization; the latter is a mandated legal structure established in most cases by state agencies. The licensure people go into a specific occupational field, especially the health field. These agencies represent one concept of accreditation.

The other is represented by the regional agencies, of which there are six in the United States. They do accreditation on an institutional basis, rather than a specialized basis. These two forms of accreditation are a phenomenon of the United States and not of most other nations of the world.

Most of the nations of the world have central commissars of education or central bureaus of education or offices by some other designation that administer all education within the federal agency. The operation is federal rather than state. I don't want to bore you with the history of the development of educational structure in the United States. What is important is that it was largely left up to local communities and states to determine their approaches to education. We have now evolved into a rather common structure of grades 1 through 12,

followed by post-secondary education which includes occupational institutions, community colleges, technical institutes, and senior colleges. All of these lead to a degree or certification in a specific field. The regional accrediting agencies have been criticized for their approach to accreditation because of the weakness in their system of setting standards to which all institutions must measure. Though the six regional accrediting associations vary widely in their method of administering the programs of accreditation, there are some characteristics common to all regional accrediting agencies in their approaches to accreditation. For instance, one of the criteria that are identified by all the regional commissions is that an institution will be measured on a basis of institutional wholeness rather than individual segments within an institution. On the other hand, agencies which give specialized accreditation look at only one segment of a spectrum within a total educational institution. For example, they would look only at inhalation therapy within the health field, and then only at the equipment, facilities, and supplies within the institution that relate specifically to that program. The fact that the institution has another instructional program, let's say, in the field of electronics, is not considered in their review process. Under the specialized concept, this is desirable. Under the institutional approach, though, which all six regional agencies follow, no institution would be reviewed for accreditation unless that institution included all fields of instruction in the structure of accreditation. A comprehensive institution may not elect to exclude a certain sector of its educational spectrum. It must include all instruction. Only under peculiar circumstances would it be allowed to exclude a specific section. Unfortunately, because of this requirement, individual programs do not get the depth of review of, say, the facilities, equipment, or administration. This is one reason that the Committee on Occupational Education came into existence in the Southern Association of Colleges and Schools.

Not only do the six regional agencies evaluate each institution as a whole, each institution prepares a self-evaluation of its programs based on the standards supplied by the accrediting agency.

In addition, a team of experts visits and reviews the institution during a period ranging from as few as one to as many as five days, depending on the complexity and size of the institution. All the regions emphasize that this team is not an inspection team. Teams have ranged in size from as high as fifty members to review an institution the size of the University of Georgia, to those as small as two or three members to review small institutions with student bodies of a hundred or fewer students. After the site visit, there is an evaluation report prepared by the visiting team which specifies the variances from standards within the institution. The important criteria on these standards is that the standards are developed and approved by the institutions themselves. In other words, it is an internal group evaluation, not an external group evaluation. After a determination by the regional agency that the institution adequately meets the standards, the institution is recommended for accreditation.

There is then a periodic review of the institution on a regular basis. This cycle of review ranges from five to ten years, depending on the regional agency. The College Commission accredits on a ten-year basis. If accepted for accreditation, an institution is accredited for ten years; there is no accreditation of less than the ten-year period. The institution must reevaluate itself at the end of every ten years.

Our occupational program has a cycle of five years because of the rapidity of change that is occurring in occupational education. At this point we feel that ten years would be ineffective because many of our institutions are less than ten years old and could see a complete change in the institutional structure in that period of time.

In addition to differences in review cycles, every regional agency establishes its own standards. There is no intent to standardize the criteria from region to region, and the regions do vary. All of them, however, have a rather common procedure for setting these standards: there is a standards committee, composed of representatives of the institutional membership, which recommends standards changes periodically to the delegate assembly. Always, it is developed under the concept that the institution does its own self study and the regional agency assigns the committee that goes in to review the institution. Authority for these operations rests with the delegate group of member institutions.

A major criticism of this setting of regional standards is that by identifying a set of criteria to which all institutions must measure, we standardize the structure of accreditation and, consequently, the structure of institutions. In other words, if there were a national set of standards relating specifically to all programs of education, then every institution in this country, because they must measure to that specific set of standards, would develop a rather standardized program of instruction. This would be equivalent to having a ministry of education that mandated what would be included in the educational system. Surprisingly enough, the standards as they relate region by region, fall into some fairly common characteristics for accreditation.

One of the important characteristics that all regions look for is the philosophy and purpose of an institution. Does it effectively relate to the mandate that the legislature or legal entity established for it? Secondly, we ask if the organization of the institution is adequate to carry out its program of education. The educational programs of the institution must measure up to certain standards regarding amount of time for matriculation and type of instruction. The staff is evaluated by the credentials of the people that are involved in the program, the length of time that the staff members teach, the types of updating or in-service training that takes place within the institution. The

physical facilities, the student personnel services, the types of prerequisites established for entry into specific instructional programs, and the learning resources of a library are also examined under this standard.

We think the results are as important as the process. We, therefore, place as much emphasis on the student that graduates from the institution and what happens to him after he leaves as we do to what happened to him while he was there, an approach that has been advocated by those in vocational and technical education for years. If graduates are placed in the fields for which they trained, if they are successful in that field, and if they can relate their experiences within the educational process to their success within their jobs, then we believe we can call their education successful. Studies indicate that what happens to the student is as important in an evaluation as the evaluation process itself.

Placement and follow-up, then, is one of the standards we identify as being crucial to an institution. The institutions must conduct not less than an annual follow-up for five years after an individual has graduated from the program.

Another traditionally neglected area that we have been extremely concerned about is the field of community relations. Our standard on community relations includes a structure regarding advisory groups. Advisory groups are crucial because they relate the instructional process to job needs and also create links between the institution and the community of which it is a part. The institutional community may range from a region of the country to a limited area of a state or city.

Another characteristic that has had significant emphasis is that of physical facilities. We have a standard on physical facilities but don't consider physical facilities to be a prime factor in evaluating institutions. We generally uphold that the quality

of the physical facilities is directly related to the instructional process, but we find that some of the best programs are in the worst facilities. The instructional program is more crucial than the facilities, but we try to encourage safe and professional facilities. We say that if you have money to invest, the first thing to build is the instructional program, then look at your facilities.

These are all important standards, characteristic of regional evaluations. In addition to these emphases that I have mentioned there is an another emphasis that takes place in an instructional program. We ask how we are going to relate the concept of specialized accreditation against that of institutional accreditation. Traditionally, the regional association has reviewed institutions by sending team members with generalist qualifications into the institutions. Now, however, the preferred group of team members that goes into that institution is that of specialists. If an institution of a community college or technical school were being reviewed, the team would normally consist of a group of generalists: a dean of instruction, a dean of student personnel services, a president of a two-year institution, a president or dean of a four-year institution, and one person in some related field, if there is a specialty. In a comprehensive community college that one additional person most frequently was an occupational educator. He was an adequate team member if he happened to be president of a college that had any of the occupational programs.

Now a typical team would not be composed of the same type of people that I mentioned, because on every one of our teams we seek to have one occupational expert in each occupational field in the institution. The size of the occupational offerings in a comprehensive institution could involve as many as twenty different occupational fields. One institution we evaluate has 172 different occupational offerings and serves 80,000 students a year. We are not going to be able to send a team into that institution with 172

specialists, but we cluster the occupations to get representative specialization. If we have three programs in the automotive field such as auto mechanics, auto body repair, and auto service, then we send an automotive specialist in to review all programs. We are modifying the concept of evaluation by generalists to guarantee occupational fields evaluation by specialists in their fields.

For instance, any institutional review that has health or health related fields in it always has at least one health educator on the team. If the institution only has one program in the health field, we always have a practical nurse instructor on the team that goes on a review. Very frequently we use supervisors, or we use administrators of similar programs. If there is a program that has seven different health fields, we have two health specialists on the team. In order to assure a breadth of experience and expertise in the specialized field there are certain characteristics we look for in people within the occupational field. In order to be a qualified member of the team an individual must have adequate background in the field. He must have supervisory or teaching experience, and not less than five years as an occupational specialist, and must be recommended by the supervisory staff of his institution. This is where we vary from specialized accreditation. Under the American Medical Association's Allied Health Fields Accreditation Program, each inspection team that goes in to review the specific programs must have a member who is a physician. We have not yet had physicians on any of our teams. We are now discussing with the American Medical Association the possibility of jointly reviewing the programs that qualify for specialized accreditation. For example, when we reviewed an institution, we would have an expert assigned by the Allied Health Fields Accreditation Program to review that institution with us. We are emphasizing that this would only be a specialized review as a part of our general review of the institution. We now give the institution the choice of requesting a member from the AMA in specialized accreditation.

We do not mandate that institutions must have specialized accreditation, but we do encourage them to consider it. The problem involved is that a very comprehensive institution could have as many as thirty-five different teams visiting that school for specialized accreditation, plus the regional accrediting agency which would review the entire institution. On this basis a school could have a team on campus almost every week for an entire year -- a rather heavy load, even on the most comprehensive institution. We think that the AMA and some other agencies we have discussed this with prefer to send their teams in simultaneously with ours. They would become a part of our team and our report. This is not practical for most regional commissions because they do not include specialists on their team, but it would work very well in our program because we do include specialists on our team. To meet the requisites of the AMA we would include at least one physician on the team for allied health fields.

One question always comes up: "What if the institution as a whole measures up, but one of those instructional programs does not?" Does it mean you accredit the whole institution and not the specialized program? This would depend on the degree of variance with our standards. As far as we are concerned, it would be the standards of our own regional accrediting agency that would make a determination about whether or not the institution would be accredited. The fact that a specialized program did not meet the criteria established by the AMA would not control whether or not we would accept the school for accreditation. Theoretically, under this structure an institution could be accredited and the specialized program might not be accredited. On the other hand, an institution might not be accepted for accreditation but specialized programs within the institution might. Now, more and more specialized agencies are relying on regional accreditation as a prerequisite for accreditation. The Engineering Council for Professional Development has adopted the policy that they will not consider an institution for accreditation in the engineering field unless it has institutional accreditation as a prerequisite.

In addition to the specialists in occupational fields, we include on our teams specialists in the areas of finance, staff, administration, philosophy, long-range planning, community relations, student personnel services, physical facilities, placement and follow-up. We put each team member through a training session prior to the time he serves on a team, so he can learn what is expected of him in an institution, and in the programs, to assure there is an adequate background evaluation for accreditation.

These additions to the team and changes in the standards are significant when you recognize that after seventy-five years of accreditation the regional agencies have spent a lot of time getting their dogma established. It is difficult to overcome the dogma in only three years, but we in occupational accreditation have done more to non-traditionalize accreditation than any other group. I am pleased to say that now all the regional accrediting agencies are interested in the occupational field. The North Central Association has for the first time in its history opened its membership to institutions that do not offer degrees.

We are not satisfied with what we have done; we do not feel that we should be held up as a perfect example in accreditation, especially in the occupational field. We will say, however, that the other regions are looking at what we are doing and considering adjustments. We still have a long way to go, but we are proud of the fact that we have moved as far as we have in the last three years.

It is a pleasure for me to be here, and I hope I have given you some information about our program. If you have any questions, we will be pleased to answer them if you will write to us at the Association in Atlanta.

THE PREPARATION OF EDUCATIONAL PARAPROFESSIONALS

Daniel H. Carter, Academic Dean
Harcum Junior College

The use and preparation of paraprofessionals in education (teacher aid) is a rapidly expanding and exciting field of post-secondary occupational education. As is true with any dynamic field this area is experiencing many growing pains. Controversies exist as to what, how, and by whom these students should be taught, what they should be called (aids, paraprofessionals, cooperative teachers, assistant teacher), the functions they should perform, the type of state certification they should receive, if any. It is not the purpose of this presentation to explore these subjects. It is my purpose to acquaint you with the two successful ongoing programs that exist at Harcum which may be classified under the broad classification of training paraprofessionals in education, how we prepare these students, and the positions they fill upon graduation from Harcum. If one wishes to explore the national status of the paraprofessional in education, I suggest beginning with a study prepared by Thelma L. Spencer, Assistant Program Director, National Teacher Examination Education Testing Survey, Princeton, New Jersey. This study examines the diversity which exists in the field on a national level.

To give more meaning and a better understanding to the program I am discussing, I feel an introduction to Harcum and its students is desirable. With this perspective one may judge the implications our program has for your college and your community. Harcum was founded in 1915 by Mrs. Edith Hatcher Harcum to educate young women in general education, fine arts, and culture, as well as an occupational skill. In 1952 the college was reorganized under its present charter. The college is a private nonprofit independent junior college and

is fully accredited by the Middle States Association. It is all female and presently enrolls 600 full-time students. Of this 600, approximately two-thirds are resident students. Most of the students are from upper middle income families from the Northeast. Approximately one-third (200) of the students at Harcum are enrolled in the two programs I am discussing.

The two programs offered at Harcum which are paraprofessional in nature are the Early Childhood Education and Paraprofessional in Education program. The great majority of students are enrolled in Early Childhood Education. According to a definition appearing in E.R.I.C. (Educational Resources Information Center), Early Childhood Education refers to group settings which are deliberately intended to effect developmental changes in children in the age range from birth to the age of entering to the first grade.[1] The Early Childhood Education Program at Harcum leads to state certification as assistant teachers in private nursery schools. The Paraprofessional in education program leads to positions in all levels of education, nursery through secondary. However, most of these students have chosen to work in the primary grades.

An applicant to the Early Childhood Education program is evaluated by the following criteria:

1. Academic potential
   (a) SAT scores -- 350 verbal -- 350 mathematics (minimum)
   (b) Ability scores -- average
   (c) Personality ratings by teachers must indicate average leadership skills, a high concern for self and others, dependability, and willingness to assume responsibility. (Students who do not show at least average leadership skills but do show responsibility are counseled to enter our Paraprofessional in Education Program. A primary difference in the two

[1] Lillian G. Katz, "Early Childhood Education as a Discipline," ERIC Clearinghouse on Early Childhood Education (Urbana, Illinois: September, 1970), p. 1.

programs is the requirement in the E.C.E. situation to assume a leadership role which is not required of graduates of the Paraprofessional in Education Program.)

2. Academic Performance - grades earned in high school should not average below "C" and should be commensurate with ability scores.

3. Personality -- The applicant must have a stable personality and be free of serious emotional problems. She should indicate a desire to work with others in a helping relationship and express a sincerity and warmth toward children. An applicant's personality status can be determined by counselor's recommendations, family background, personal interviews, and by the number and kinds of activities in which the applicant participated in high school. (If after a student enters the program, it is judged that a poor interpretation of the student's personality or other capacities was made, the student is encouraged to change her course of study.)

4. Interests -- An interest in working with young children, as revealed by baby-sitting, camp, and other activities is of primary importance.

5. Health -- Applicant should be in good health, free of speech handicaps or physical handicaps that would endanger the safety of young children. Health is determined by health records in high school and number of days of school missed.

For the Paraprofessional in Education Program we are looking for an applicant who wants a position in the educational field. The applicant should be a good responsible follower and one who does not desire or is not capable of a leadership role.

The applicant for Paraprofessional in Education is evaluated much as one is for the Early Childhood Education program with the exceptions that (1) academic potential is not required to be as high (however, high school grades which are commensurate with abilities is still very important -- if a student is an underachiever, then irresponsibility must be ruled out as the cause). (2) Secondly, leadership traits are not as essential.

One must be very careful in the admission policy. If a poor job is done at this stage, the program will be in serious difficulty from the beginning, and students who are misplaced will be unhappy and possibly injured. Unfortunately, it is not enough to know that a need exists or that jobs are available to recommend these programs to a student.

As stated in the Purposes and Objectives of our college, the college's primary purpose is "to prepare students to take their chosen places in today's world equipped not only with necessary academic and career skills but also with self and social awareness." To this end the college offers courses in the arts and sciences which add dimension of breadth and depth to the high school experience. Thus, all programs at Harcum, including the two being discussed, have requirements in English, sciences, and social sciences. The E.C.E. program requires twelve semester hours of English and eight semester hours of Science. A strong background in psychology and sociology is important to these students. To meet this need, eighteen semester hours of social science is included in the program. The remaining twenty-six semester hours of the program are education courses, namely: Foundations of Education, Early Childhood Education, Creative Experiences for Pre-School and Primary Children, Reading Readiness and Children's Literature, Intellectual Activities for Pre-School and Primary Children, and Student Teaching and Practicum.

The Foundations of Education and Early Childhood Education courses are introductory survey courses of the fields of education and early childhood education

respectively. Not only are classical situations explored, but the current trends in these two areas are also considered. Observations of different programs such as GET SET, Montessori, and Discovery Centers are made to give a broad understanding of special concepts of early childhood education.

The Intellectual Activities course explores the methods used and the materials available for teaching concepts, readiness for and skills in science, social science, language arts, and mathematics. This course, along with many of the other courses in this curriculum, is a learning-by-doing course. The students conduct the same experiments in the classroom that they will perform in a nursery school.

In Reading Readiness and Children's Literature, students discuss preparing the nursery school child for first grade reading. The purpose of this is not how to teach a child to read but how to give the child experiences that enable him to learn to read. There is emphasis upon two skills which must be developed before a child learns to read -- the ability to hear the separate sounds in spoken word and the ability to see the separate sounds in the written word.

Creative Experiences is a two-semester course. The first semester deals with art and music, while the second semester adds drama in a learning-by-doing course. Each student is required to demonstrate before her fellow classmates with a presentation which integrates art, music, and drama. Any rigidity the student may have is broken down, and this allows her to recognize freedom of expression in these three areas. All concepts are taught through "acting-out" of nursery rhymes, stories, records, and paintings. It is total involvement -- physical, emotional, and intellectual. The student's imagination is stimulated to the degree that she may encourage the creativity of each individual child and she is encouraged to use all possibilities of drama, music, and art. Finger plays, flannel board activities, games, puppets, autoharps, rhythm bands, creative dance,

paintings, paper mache, clay, finger paints, and many other techniques are all integrated and used to encourage creativity.

The ultimate in the practical experience occurs in the student teaching experience, when the student applies all the concepts that she has learned. She has an opportunity to coordinate all the information she has received and to integrate her physical and mental abilities in performing as a teacher. The student spends a minimum of 180 hours (three hours a day, five days a week for twelve weeks) in a licensed private nursery school or kindergarten working with a certified teacher. The students also spend one hour each week with the Harcum supervisor. Students are required to keep detailed daily records of the complete program of the nursery school, the reactions of three different types of children (such as aggressive, shy, withdrawn, or a child with a special medical problem) to each area of the program, and the guidance principles used in the handling of these different personality types. All success or failure of the program in relation to the three types of children are appraised and the student is required to suggest, in her daily records, reasons why the program was a success or failure with concrete suggestions for improvement. The daily record kept by the student is used as a basis for classroom discussion. It is hoped that the records kept on different personalities will make the students more sensitive to the needs of individual children. The students begin their student teaching with a period of observation, then take over simple tasks, eventually moving up to planning and executing a full day or week in the school to which they are assigned. The practical experience prepares a girl to step into a pre-school teaching experience immediately upon graduation and complies with the suggestion of Commissioner of Education, Sidney P. Marland, that exposure to the world of work be introduced into our schools.[2] (Much of the grade in this course

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[2]"New Ideas for Better Schools." Interview with the U.S. Commissioner of Education, *U.S. News and World Report* (November 1, 1971) pp. 80-85.

comes from the evaluation submitted by the student's supervising teacher.)

Upon graduation the student is certified by the State of Pennsylvania to be an assistant teacher in private nursery schools and kindergartens. Full teacher certification is obtained by earning a Bachelor of Science degree at a four-year institution or by earning six credits beyond the basic program and demonstrating two years of successful teaching experience. These additional six credits can be taken at Harcum.

Upon graduation these students may go into private nursery schools, kindergartens, and public schools as aids or assistant teachers and appropriate job classifications of Get Set programs. They find employment in day care centers in many capacities, including directors. In view of the expansion of day care centers, Harcum is exploring the possibilities of new courses that would give more training in this area for students who want this emphasis. Courses are presently being given by Harcum in center city Camden to meet the needs of day care centers there, and the possibilities of incorporating a day care center for student observation into our present nursery school is also being explored.

The Paraprofessional in Education curriculum is similar to the Early Childhood Education curriculum in English and Science. However, only nine semester hours of social sciences are required. The education courses taken are Role of the Paraprofessional in Education I and II, Library Practices and Procedures, Instructional Media, and Practicum. This is a total of eighteen semester hours. The rest of the program is composed of free electives.

The role of the paraprofessional in education was developed to help the student understand the duties and responsibilities of the paraprofessional in the educational process. One way she discovers this role is by studying the responsibilities of all positions represented

in the education process from school board member on down. "Who is to do what" to help children learn is a very important concept in assuming the responsibilities of a paraprofessional. Attention to specific duties and observations of schools and school personnel give depth to the understanding of this role. A course in Library Practices and Procedures is included to acquaint the student with the function and operation of a library.

The Audio-visual Instruction course at Harcum is designed to present instruction and laboratory experience in the preparation of instructional media and the operation of audiovisual equipment, and to present theory relative to the best practices in audiovisual techniques.

Students receive on-the-job training in a six semester-hour practicum course. This course requires the student to spend 180 hours in a school working as a paraprofessional. Rather than working half days, as is best for the student teacher in the Early Childhood Education program, these students work two full days a week in the schools. They may work in private or public schools in the first grade through twelfth grade. Most of our students choose to work in public schools in the primary grades. A major portion of the student's grades in this course is determined by her direct supervision in the school in which she is placed.

At Harcum the transferability of a program falls into three broad areas:

1. programs designed solely for transfer (e.g. liberal arts, medical technologist, etc.)

2. those designed without regard to transfer (secretarial, medical assistant)

3. programs where trained students can find employment upon graduation or which transfer to four-year colleges.

The Paraprofessional in Education program falls into the second category. It is designed for the student to find employment upon graduation from Harcum. Some of the courses in the curricula will transfer but many will not. The Early Childhood Education program falls into the third category (job preparation and transfer). Although students have taken skill courses which enable them to begin their careers immediately, they also have taken a series of strong transferable courses and have little problem transferring and securing a bachelor's degree with two additional years of study, if they so choose.

EVALUATION OF THE CONFERENCE

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The major objectives of the conference, as stated in the welcoming letter to the conferees, were the following:

1. To consider the role of two-year colleges in the planning and providing of programs in social and health related paraprofessional occupations.

2. To provide the participants with information that would better enable them to identify some of the elements and useful approaches for planning and conducting such programs in their institutions.

3. To provide an opportunity for educators concerned with post-secondary occupational education to meet for the purpose of exchanging ideas and viewpoints on topics associated with social and health related service programs, particularly:

   a. statewide planning for programs;
   b. licensing and certification of health service personnel;
   c. accreditation of social and health related service programs.

4. To continue with the series of cooperative ventures between the university and Pennsylvania post-secondary institutions which are aimed at contributing to the overall improvement of post-secondary occupational education.

The evaluation device designed to measure the extent to which the above mentioned conference objectives were met consisted of a short checklist questionnaire sent to all conference participants and a telephone interview of a randomly selected number of conference participants.

The checklist questionnaire was mailed to the conference participants on November 15, 1971 with a return self-addressed stamped envelope. On November 29, 1971 a remainder post-card was mailed to conference participants urging them to complete the evaluation checklist if they had not already had the opportunity to do so. Approximately 77 percent (58) of 74 mailed checklist questionnaires were returned completed. Questionnaires were not mailed to graduate assistants in the department. Approximately 33 percent (19) of the questionnaires were returned with additional comments written on the reverse side.

Approximately 29 percent (24) of the conferees were contacted by telephone between November 15-24, 1971 by graduate assistants in the Department of Vocational Education, The Pennsylvania State University. Each conferee was asked to respond to six questions to help us evaluate the conference and assist in the planning of the next conference. See Appendix D for the questionnaire, follow-up post-card, and telephone interview. The materials that follow are the results of the conference follow-up questionnaire and telephone interviews.

Attendance

The attendance at the sessions, which was arrived at from the returned questionnaires and graduate assistants counting the number of persons at each session, is displayed in the following table.

Table I

Speakers	From Questionnaire (58=100%)			By Head Count	
	Rank	N	%	Rank	N
Sussman	1	(54)	(93%)	4	(70)
Martorana	2	(53)	(91%)	2	(75)
Ducanis	4	(51)	(88%)	3	(74)
Ellis	5	(48)	(83%)	5	(65)
Pennell	6	(46)	(79%)	6	(62)
Whyte	8	(41)	(71%)	7	(60)
Burns	7	(45)	(78%)	5	(65)
Childer	3	(52)	(90%)	1	(80)
Carter	9	(39)	(59%)	8	(50)
Discussion Groups					
1st-Statewide Planning	1	(34)	(59%)	2	(52)
2nd-Licensing and Certification	2	(30)	(52%)	3	(38)
3rd-Accreditation	3	(27)	(47%)	1	(57)

The attendance by conference participants replying to the questionnaire as indicated by the chart places the conference opening talk "The Role of the Two-Year Colleges in Providing Social and Health Service Planning" (Sussman) as the most heavily attended followed by Statewide Planning (Martorana) and Accreditation (Childers). The rank order by head count places the opening conference talk fourth in attendance, "Accreditation" (Childers) as the most heavily attended, followed by "Statewide Planning" (Martorana and Ducanis). The dinner talk "Health Care: System or Non System with Implications for Training" ranked fifth (which is in the middle) by participants and head count. Next ranking was "Licensing and Certification" (Pennell and Whyte). The conference closing luncheon talk "The Preparation of Educational Paraprofessionals" ranked last on both the questionnaire and head count.

Objective One: Role of Two-Year Colleges in Planning and Providing Programs

Question two on the questionnaire asked the conference participants:"Which presentation provided the most information relative to the role of two-year colleges in planning and providing of programs in social and health related paraprofessional occupations?" Twenty-one percent stated that both "Statewide Planning for Delivery" (Martorana) and "The Two-Year College Role" (Sussman) provided the most information followed by eleven percent for "Statewide Planning--Some Concepts" (Ducanis), ten percent for "Accreditation of Human Health Resources" (Childers), and nine percent for "Seeing is Believing, Planning is Projecting" (Burns). The topic "Licensing and Certification-Another View" (Whyte) provided the least information relative to this question.

Objective Two: Provide Information to Identify Elements and Useful Approaches in Their Institutions

Questionnaire: Eighteen percent of the questionnaire respondents stated that "Seeing is Believing, Planning is Projecting" (Burns) provided them with the most information that would better enable them to identify elements and approaches for planning and conducting programs.

Telephone Reply: The conference participants were first asked:"Which presentation was most relevant to their jobs?" Twenty-five percent stated "Accreditation of Human Health Resources" (Childers), followed by 21 percent for both "Statewide Planning" (Martorana) and the "Two-Year College Role" (Sussman), and 12.5 percent for "Statewide Planning--Some Concepts" (Ducanis).

When asked which presentation provided them with information that will assist them in either implementing new practices or improving some of their present practices 21 percent stated "Accreditation" (Childers), followed by 12.5 percent each for "Statewide Planning" (Martorana), "Community Planning for Health Care," (Ellis) and "Licensing and Certification" (Pennell).

Combining the questionnaire and telephone evaluation, the three presentations that provided the most information that would enable identifying elements and useful approaches both for planning and conducting programs were "Accreditation" (Childers), "Community Planning for Health Care" (Ellis), and "Statewide Planning" (Martorana).

The last question asked in the telephone interview was:"how would you implement the new information?" if the preceding question was answered affirmatively. There were many answers to this question, but the following five were emphasized more than once: feel that I have enriched my understanding which will help me in performing my job; follow-up on contacts made at the conference and would like to try and implement allied health

programs at my institution; area of specialization will be getting into certification in the near future and found the information presented helpful in looking for additional information; and, the talks will help me work with my advisory council.

Other ideas expressed were: would like to increase number of programs; look to others when planning; implement the information in the courses he teaches; awareness of the need for a greater voice in supervision; recognize the need to devote more time to individual differences; and helpful in reviewing programs in existence.

Objective Three: Exchange of Ideas and Viewpoint on Statewide Planning, Licensing and Certification, and Accreditation

Questionnaire:

Statewide Planning - Eighteen percent stated that both "Statewide Planning for Delivery" (Martorana) and the first discussion group provided the most ideas, followed by 16 percent stating the second discussion group and 13 percent stating the coffee intermission.

Licensing and Certification - Twenty-four percent did not respond to this question. Twenty-two percent voted for "Licensing and Certification" (Pennell), followed by 14 percent for both the second and third discussion groups.

Accreditation - Twenty-four percent stated that "Accreditation" (Childers) provided the greatest exchange of ideas, while thirteen percent said both the second and third discussion groups. Twenty-four percent did not reply to this question.

Telephone Reply - When asked, "Which of the following three topics was most relevant to you?" 41 percent replied "Statewide Planning," 33 percent replied "Licensing and Certification," and 26 percent mentioned "Accreditation."

The principal presentors in each of the three main topic areas provided the most exchange of ideas and viewpoints (Martorana, Pennell, and Childers), with the discussion groups following each presentation ranking second. In "Statewide Planning" the coffee intermission ranked third, but in "Licensing and Certification" the third discussion group ranked third. It is interesting to note that the second discussion group ranked third in the "Accreditation" question. This discussion group was held prior to the accreditation talks!

Objective Four: Continuance with the Series of Cooperative Ventures

Suggestions for the topic of next year's conference were asked for in the telephone interview. The six most frequently mentioned topics were: articulation of area vocational technical schools; two-year and four-year programs; manpower needs and designing successful programs to meet the needs; evaluation of programs and facilities; accreditation and certification -- national to local level; developing a child care center; and engineering topics. Other suggestions were: curriculum planning, law enforcement, business topics, procuring federal funds for programs, vocational counseling, assessment of skill areas, administration of vocational education institutions, equivalency and professional testing, should AVTS offer associate degrees, study of curriculum development for AVTS, post-secondary advisory committees, trends in technical education, meeting student needs in one-year programs, social services, more on two-year and four-year health curricula, environmental education-interdisciplinary study, and practicum speakers in human services with statistically oriented information.

When the conference participants were asked for ways in which The Pennsylvania State University can better serve post-secondary occupational institutions and their faculties, one-third of the telephone respondents felt that the leadership workshops should be continued, particularly on a broad basis. Twenty-five percent said

the university should act as a council center in terms of providing teacher resources and information dealing with nationwide and statewide development, 17 percent stated research, and 12.5 percent thought we should be more specific and emphasize a pragmatic approach.

Other suggestions mentioned with less frequency were: communicating news of successful programs through reports to the schools, encouraging more teacher participation, having discussion groups related to other topics, having more people from the world of work participate, encouraging coordination between Commonwealth Campuses and community colleges, sponsoring summer term programs for faculties of occupational institutions with financial assistance, and offering mini-courses.

Comments

Questionnaire: Eighteen questionnaire respondents made additional remarks on the reverse side of the questionnaire. Nine commended the planning, program, facilities, and hospitality. Five felt the topics presented were too broad and that there weren't enough actual curriculum ideas presented for the practitioner. Additional comments made by the participants were: time limit on speakers should be adhered to; program too long with after-dinner and breakfast speakers; conference title deceiving for what was offered; limit discussion topics and go into greater in-depth discussion and dialogue; cut out evening meeting; provide names and addresses of contact people; get the conference monograph out sooner; have examples of model type programs; and allow more time for interaction with major presentors.

Telephone Reply: The following additional comments were received through the telephone interviews. Six persons indicated that they would like to see the conference become less abstract and have a more practical approach. Other comments were: discussion groups should be drop-in sessions; didn't like evening sessions; never defined curriculum and what the health services need in their curricula; and have an open bar before the conference begins.

Conclusion

The topic presentations all ranked high in measuring the objectives of the conference except "Licensing and Certification: Another View" (Whyte) and the "Preparation of Paraprofessionals in Education" (Carter). The second discussion group meetings were the least attended of all the discussion group meetings. Whyte's talk and the second discussion group meetings were the last two meetings of the evening session, and Carter's talk was the last item on the conference agenda. The evening hour and the position of speaking last on the agenda are contributing factors to the ranking of the above talks and discussion group meetings.

The suggestions for next year's conference and ways in which The Pennsylvania State University can better serve post-secondary occupational faculties and institutions along with additional comments made by conference participants indicate that The Pennsylvania State University is serving the needs of these institutions and their faculties. It is evident that these institutions and their faculties desire more involvement with other post-secondary occupational institutions in Pennsylvania in the form of additional meetings during the year and implementation of written communications on issues relevant to each other.

APPENDIX A

Program
Third Annual Pennsylvania Conference on
Post-Secondary Occupational Education

CONFERENCE DIRECTOR: Dr. Angelo C. Gillie, Professor
Department of Vocational Education
The Pennsylvania State University

CONFERENCE ADVISORY COMMITTEE CHAIRMAN: Mr. Robert L. Sheppard
Bureau of Academic Services
Department of Education
Commonwealth of Pennsylvania

TOPIC: PLANNING AND CONDUCTING SOCIAL AND HEALTH RELATED SERVICE PROGRAMS

DATES: November 10-11, 1971

PLACE: J. Orvis Keller Conference Center
The Pennsylvania State University

AGENDA:

November 10, 1971

11:00 a.m. - 12:00 noon Registration, Conference Center, Lobby

12:00 noon - 1:00 p.m. Luncheon, Multipurpose Room
Conference Center, Ground Floor

Toastmaster: Dr. Abram W. VanderMeer, Dean
College of Education
The Pennsylvania State University

Welcoming Remarks: Dr. G. Lester Anderson, Director
Center for the Study of Higher Education
The Pennsylvania State University

Dr. Robert L. Lathrop
Associate Dean for Resident Instruction
The Pennsylvania State University

Mr. Robert L. Sheppard, Chairman
Conference Advisory Committee

1:00 p.m. - 1:30 p.m. Luncheon Speaker: Mr. Herbert Sussman, President
Community College of Allegheny County
Allegheny Campus
Pittsburgh, Pennsylvania

Topic: "The Role of Two-Year Colleges in Providing Social-Health Service Programs"

1:30 p.m. - 3:00 p.m. Topic I, Conference Center, Room 402-03

"State-Wide Planning of Two-Year Programs for Delivery of Human Health Services: Needs, Problems, and a Look into the Future"

Chairman: Dr. James W. Selgas, Director
Research and Community Resources

Presentor: Dr. S.V. Martorana
Vice-Chancellor for Two-Year Colleges
State University of New York
Albany, New York

Presentor: Dr. Alex J. Ducanis, Director
Institute for Higher Education
University of Pittsburgh
Pittsburgh, Pennsylvania

3:00 p.m. - 3:30 p.m. Coffee and Informal Discussion, Fourth Floor Corridor
Conference Center

3:30 p.m. - 4:30 p.m. Small Discussion Group. Sessions A. Conference Center

Discussion Leader I: Dr. Michael Sugarman (Room 112)
Assistant Professor
University of Akron
Akron, Ohio

Discussion Leader 2: Mr. George Elison
Dean of Technologies
Lehigh County Community College
Schnecksville, Pennsylvania

Discussion Leader 3: Mr. Charles Gilmore (Room 114)
Division Director
Community College of Philadelphia
Philadelphia, Pennsylvania

Discussion Leader 4: Mr. Edward Sutton (Room 405)
Assistant Dean of Faculty
Community College of Allegheny County
Allegheny Campus
Pittsburgh, Pennsylvania

4:30 p.m. - 5:30 p.m. Free Time

5:30 p.m. - 6:00 p.m. Hospitality Cash Bar, Assembly Room, Nittany Lion Inn

6:00 p.m. - 7:30 p.m. Dinner, Main Dining Room, Nittany Lion Inn

Toastmaster: Dr. G. Lester Anderson, Director
Center for the Study of Higher Education
The Pennsylvania State University

Dinner Speaker: Dr. Edward V. Ellis, Associate Dean for Continuing Education and Associate Professor for Public Health
College of Human Development
The Pennsylvania State University

Topic: "Health Care: System or Nonsystem with Implications for Training"

7:30 p.m. - 8:15 p.m. Topic II, Conference Center, Room 402-03

"Licensing and Certification of Health Services Personnel"

Chairman: Mr. Robert L. Sheppard
Bureau of Academic Services
Department of Education
Commonwealth of Pennsylvania

Presentor: Mrs. Maryland Y. Pennell, Chief
Office of Special Studies
Division of Allied Health Manpower
National Institute of Health
Bethesda, Maryland

Presentor: Mr. Douglas Whyte, Head
Department of Human Service Careers
Community College of Philadelphia
Philadelphia, Pennsylvania

8:15 p.m. - 8:20 p.m. Coffee, Conference Center, Third Floor Corridor

8:20 p.m. - 10:00 p.m. Small Discussion Group. Session B. Conference Center

Discussion Leader I: Dr. Robert J. Foster (Room 301)
Assistant Professor
College of Engineering
The Pennsylvania State University

Discussion Leader 2: Dr. Warner Carlson (Room 311)
Assistant Dean of Faculty for Life Sciences
Community College of Allegheny County
Allegheny Campus
Pittsburgh, Pennsylvania

Discussion Leader 3: Mr. Thomas S. Powell (Room 305)
Assistant Director
Hospital Association of Pennsylvania
Camp Hill, Pennsylvania

Discussion Leader 4: Mr. Eugene Kray (Room 306)
Assistant Dean of Instruction
Community College of Delaware County
Media, Pennsylvania

November 11, 1971

7:30 a.m. - 9:00 a.m. Breakfast, Main Dining Room, Nittany Lion Inn

Toastmaster: Mr. Robert L. Sheppard
Division of Two-Year Programs
Bureau of Academic Services
Pennsylvania Department of Education
Harrisburg, Pennsylvania

Speaker: Dr. Martha Burns
Coordinator of Education Counseling for Adult Students
Continuing Education
The Pennsylvania State University

Topic: "Seeing is Believing, Planning is Projecting: Human Service Programs"

9:00 a.m. - 10:00 a.m. Topic III, Conference Center, Room 402-03

"Accreditation of Social and Health Related Service Programs in Two-Year Institutions"

Chairman: Dr. Fred Snyder, Director
Research and Planning
Virginia Department of Community Colleges
Richmond, Virginia

Presentor: Dr. Bob Childers
Executive Secretary
Committee on Occupational Education
Southern Association of Colleges and Schools
Atlanta, Georgia

10:15 a.m. - 10:30 a.m. Coffee and Informal Discussion, Fourth Floor Corridor Conference Center

10:30 a.m. - 12:00 noon — Small Discussion Group. Sessions C. Conference Center

Discussion Leader I: Dr. Albert J. Pautler (Room 112)
Associate Professor
SUNY at Buffalo
Buffalo, New York

Discussion Leader 2: Dr. Harvey Oates (Room 113)
Division Director
Community College of Philadelphia
Philadelphia, Pennsylvania

Discussion Leader 3: B. Michael Hollick
Chairman, Division of Life Sciences
Harrisburg Area Community College
Harrisburg, Pennsylvania

Discussion Leader 4: Mrs. Virginia Moore (Room 405)
Executive Secretary
State Board of Nursing Examiners
Harrisburg, Pennsylvania

12:00 noon - 1:30 p.m. — Luncheon, Multipurpose Room
Conference Center, Ground Floor

Toastmaster: Dr. Kenneth P. Mortimer
Assistant Professor of Higher Education and Research Associate
Center for the Study of Higher Education
The Pennsylvania State University

Speaker: Dr. Daniel Carter, Academic Dean
Harcum Junior College
Bryn Mawr, Pennsylvania

Topic: "The Preparation of Educational Paraprofessionals"

1:30 p.m. - 2:00 p.m. — Conference Wrap-Up: Concluding Comments
Conference Center, Room 402-03

Dr. Angelo C. Gillie
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APPENDIX B

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APPENDIX C

The Conference Advisory Committee

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APPENDIX D:

Conference Evaluation

THE PENNSYLVANIA STATE UNIVERSITY
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College of Education
Department of Vocational Education

November 17, 1971

Dear Conference Participant:

One of the final concerns we have relative to the Third Annual Pennsylvania Conference on Post-Secondary Occupational Education is the extent to which the conference achieved its objectives. Nearly half of the registrants have been interviewed as the first phase of our evaluation. The second phase is to ask every person registered at this event to respond to six items.

Enclosed is a short conference evaluation form. A check mark should be placed in the boxes that apply to each question. If you have any additional comments, feel free to write them on the reverse side of the questionnaire. Please return the questionnaire in the enclosed self-addressed, stamped envelope.

Your assistance and suggestions will certainly help us in planning future conferences. The results of the evaluation will also be included in the forthcoming monograph. Thank you for your cooperation.

Sincerely,

Angelo C. Gillie
Professor
Graduate Studies and Research

ACG/rzm/bh

Enclosures

QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS BY PLACING A CHECK ( ) MARK IN THE BOXES THAT APPLY.

	Which sessions did you attend?	Which presentation provided the most information relative to the role of two-year colleges in the planning and providing of programs in social and health related paraprofessional occupations?	What presentation provided you with the most information that would better enable you to identify elements and useful approaches for planning and conducting social and health related service programs in your institution?	Where did the most satisfactory exchange of ideas and viewpoints on statewide planning for programs take place?	Where did the most satisfactory exchange of ideas and viewpoints on licensing and certification of health service personnel take place?	Where did the most satisfactory exchange of ideas and viewpoints on accreditation of social and health service programs take place?
The Two-Year College Role (Sussman)						
Statewide Planning for Delivery (Martorana)						
Statewide Planning Emphasis Beyond (Ducanis)						
Community Planning for Health Care (Ellis)						
Licensing and Certification (Pennell)						
Licensing and Certification - Another View (Whyte)						
Seeing is Believing; Planning is Projection (Burns)						
Accreditation of Human Health Resources (Childers)						
Training Paraprofessionals (Carter)						
First Discussion Group						
Second Discussion Group						
Third Discussion Group						
Coffee Intermissions						

140

Follow-up Telephone Interview for Conference Evaluation

This is _____ of PSU calling. I am Dr. Gillie's graduate assistant, and we are conducting a brief follow-up study of the conference on post-secondary occupational education which you attended on November 10th and 11th.

Will you help us determine the extent to which the conference objectives were met? You can help by responding to six questions. This won't take more than five minutes of your time.

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1) What are two topics that you would like to have considered for the 4th annual Pennsylvania Conference on Post-Secondary Occupational Education?

2) What are some of the ways in which PSU can better serve post-secondary occupational institutions and their faculties?

3) Which of the following three topics conducted in the conference was most relevant to you:

   a) Statewide planning
   b) Licensing and Certification
   c) Accreditation

4) Which presentation was most relevant to your job? (Would you want me to name them all for you?)

5) Which presentations provided you with information that will assist you in either implementing new practices or improving some of your present practices?

6) Briefly describe how you would implement this information. (Skip this question if #5 is negatively answered.)

Conclusion::: Thank you for your cooperation. Your assistance and suggestions will be of help in planning the next conference. The results of this evaluation will also be included in the forthcoming monograph.

Follow-Up Postcard

12/1/71

You recently received a short questionnaire in the mail to evaluate how effectively the THIRD ANNUAL PENNSYLVANIA CONFERENCE ON POST-SECONDARY OCCUPATIONAL EDUCATION objectives were met.

If you haven't had the opportunity to complete your evaluation, will you take a few minutes to check the appropriate answers and return the check list to us.

Thank you for helping us to evaluate the conference.

Angelo C. Gillie

APPENDIX E

Discussion Groups

Directions to Discussion Leaders

THE PENNSYLVANIA STATE UNIVERSITY
247 CHAMBERS BUILDING
UNIVERSITY PARK, PENNSYLVANIA 16802

College of Education
Department of Vocational Education

As you know, the presentations made at this conference will be published in a monograph by The Center for the Study of Higher Education here at The Pennsylvania State University. I would like to consider the possibility of including discussion group summaries in the publication. In light of this, would you be kind enough to prepare a summary of the proceedings of the discussion group in which you will be a leader? I would suggest that you write in the third person and do not use the names of the discussion group participants. It is more readable by referring to comments made by someone in the group in a general way (example: one of the participants indicated his disagreement with the idea of having both curriculum and institutional accreditation. After some discussion, the consensus of the group seemed to be in agreement with that statement. ...etc). I would also suggest that you not try to keep notes of what goes on in your group. Rely on your own impressions of the overall trends taken by the group. If you could get your thoughts on the outcomes of the group in writing within a day or two, chances are your memory will serve you sufficiently well to provide a good overview. Also, in the interest of trying to meet a publication deadline, I would like to have your overview within a week or so after the conference (before the Thanksgiving holiday). One to two double-spaced typewritten pages is a suitable length.

Thanks for your willingness to serve as a Discussion Leader and also for making the proceedings of the group available for publication. Feel free to contact me if you should need additional clarification.

Sincerely,

Angelo C. Gillie
Professor
Graduate Studies and Research

ACG/rzm

Group Discussion A

Dr. Michael N. Sugarman, Discussion Leader

Dr. Sugarman opened the discussion session by presenting a brief reaction paper* directed toward the presentation of Dr. Martorana.

Much of the discussion of this group centered around the problems of specialization and differentiated staffing within the health delivery system. Who takes care of the total patient? Members of the group sensed a need for a *health counselor* within the clinical setting, a member of the health team who could relate directly to the patient as the many technicians come and go during one's stay in a hospital.

The group also considered the possibility that the *nurse*, as we know her, may be obsolete in the near future as the practical nurse and the many technicians take over her duties in the modern hospital. Some of the participants felt that many of our education and training programs are producing over-specialized practitioners for jobs that may not exist shortly after graduation.

The education of the allied-health technician drew most of the attention of the group in response to the statement of Dr. Sugarman that "there may be a direct relationship between the quality of health services provided in a community and the quality of the community college faculty who train the allied-health practitioner."

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*See Appendix F.

Group Discussion B

Mr. George Elison, Discussion Leader

The session was opened with an identification of all participants and the institutions which they represented. It was determined that there were six different types of institutions represented who were interested in offering Social and Health Related Service Programs leading to the Associate Degree. These were:

Community colleges
Public schools with established adult skill centers
A campus of The Pennsylvania State University
Proprietary schools
Four-year institutions
A health education center established under the new guidelines

An examination of the location of these institutions revealed that as many as three different types of institutions from the same area were considering the establishment of health related programs, and that no one was providing leadership to insure that facilities and programs were not duplicated needlessly.

The discussion of the group revolved about the following items:

Statewide planning for health care delivery.
Statewide planning for health service programs.
To what extent is statewide planning necessary?
Who should be responsible for planning?
Should implementation of plans be optional or mandatory?

The group collectively had such an interest in curriculum development that the discussion frequently reverted to this topic, thus reducing the extent to which the matter of statewide planning could be discussed. There was general acceptance that some form of coordinated

planning would be necessary to eliminate duplication, waste, and an oversupply in some occupations. However, there was little agreement as to the manner in which this planning should be brought about.

Group Discussion C

Dr. Albert J. Pautler, Discussion Leader

The members of the group decided to focus the discussion on two main topics. First, concern was on the statement made by Dr. Childers regarding equal emphasis on *product* as well as on *process* in the accreditation system used by the Southern Association of Colleges and Schools. Second, a member of the group suggested that we spend some time discussing teacher preparation programs designed to prepare health related instructors for the post-secondary institutions.

Dr. Childers visited with our discussion group and was able to expand upon his statement regarding *product* vs. *process* evaluation of programs. The accreditation team is equally concerned with the educational process (teaching-learning) as well as the product (the graduate). The product is followed up yearly for five years after graduation to determine how successful he is on the job as well as to feed back information that might result in improvements of the institution's program. The members of the discussion group considered such a dual evaluation worthwhile to any evaluation scheme. Success on-the-job is equally important and related to the in-school activities.

Time did not permit a full discussion of the second point dealing with the preparation of health related teachers. It appeared that obtaining qualified health related teachers can be a problem. It might be that such a theme could be the subject for another meeting of this same type.

Group Discussion D

Mr. B. Michael Hollick, Discussion Leader

The discussion centered around the problem of providing quality Allied Health Education within a flexible configuration capable of being sensitive to manpower needs.

One gentleman indicated that a basic education core should be established pertinent to all allied health areas. Another added that this core should have at its base a fundamentals of nursing course from which the student may proceed in some specific direction realistic to his ability.

The question of "career ladder" was raised and one individual expressed the opinion that such a thing in reality does not exist. Sentiment was expressed that challenging exams are an important factor in making this concept a reality. Students passing such exams should not simply be exempt from a particular course, but should be given credit for that requirement. Someone raised the question of accreditation and transferability with programs granting credit by examination. It was generally agreed that the former was no real problem and that to protect the student for transfer purposes, notations on his permanent transcript records should indicate his receiving the credits by examination.

It was generally agreed that the era of restriction by accreditation in the areas of curriculum change and innovations has largely passed. Greater flexibility in these areas is viewed as beneficial, and this is now being provided in the accreditation process.

Group Discussion E

Mrs. Virginia Moore, Discussion Leader

The meeting opened with a statement about the preliminary report by Dr. Martha A. Burns entitled *New Careers in Human Service: A Challenge to the Two-Year College*, which sets forth simple guidelines for the three approaches to and the five component parts of the curricula. It was recommended that the report and the follow-up handbook be distributed in the future, be reviewed and used as a guide because at the two previous meetings of Conference Group 4, concern was expressed as to ways in which to move in order to plan a core for the preparation of health workers in community colleges.

The role of the advisory committee as presented by Dr. Burns' paper was discussed. There was no agreement as to the advisory committee's responsibility to prepare the curriculum prior to the hiring of the Director of Nursing of an associate degree nursing program. It was felt by some that the advisory committee could prepare the curriculum and the Director of Nursing could be hired about one month prior to the implementation of the same curriculum. Some of the participants indicated that the advisory committee has no place in preparing the curriculum because this is the responsibility of the Director of Nursing as she and the faculty are responsible for implementing it.

A discussion followed as to whether or not an advisory committee is necessary. It was agreed by the majority that the advisory committee can be most helpful in its role of giving advice, assisting with public relations, in the area of recruitment, obtaining scholarship monies, and in establishing loan funds.

The State Board of Nurse Examiners, in establishing an approved program of nursing, requires that the Director of Nursing be employed at least twelve months prior to the intended admission date. Some felt this was unrealistic.

The associate degree institutions are on strict budgets, and to employ a full-time Director of Nursing one year prior to the admission of students to the program poses a fiscal problem. One participant stated that five or six months time should be adequate lead time for the newly appointed Director of Nursing to be employed.

This then led into a discussion of whether or not the Director of the Associate Degree Nursing Program can be or should be responsible for the administration of all programs in the health field area. It was pointed out that to prepare a safe practitioner in a two-year associate degree program, the Director of Nursing had to concentrate all her efforts in implementing and assuring a quality program. It was suggested that specific guidelines be made available to the community colleges so that they could then plan a core-curricula for health workers. A question was raised as to the makeup of the State Board of Nurse Examiners, and it was suggested that consideration be given to the appointment of a representative from the area of community colleges.

A question was raised as to the necessity for the State Board Test Pool Examinations "on top of" the degree issued by the parent institution. One participant felt that this is a duplication, inasmuch as the Department of Education gives permission to the community colleges to offer an associate degree. The point was made that this may be a case of one governmental agency questioning the standards of a second governmental agency. The participant felt that the certification from the community college of a graduate is sufficient and the licensing examination is superfluous. It was agreed that a national examination with national norms is required to identify the type of product Pennsylvania prepares, and assists the product to move into other jurisdictions. It was also agreed that more emphasis should be placed on the quality of the program which will in turn take care of the concerns regarding the licensing examination.

A question was raised as to the reading level of the examination and whether or not it is fair to have the

two-year graduate and the four-year graduate take the same examination. It was pointed out that the State Board Test Pool Examination tests for minimum knowledge in order to license "safe" practitioners. One participant felt that the examination for the associate degree graduate should be on a lower reading level than the examination given to the baccalaureate degree graduate.

It was evident that the group was seeking answers to questions they had concerning methods of preparing the health workers needed by today's society.

Group Discussion F

Mr. Thomas S. Powell, Discussion Leader

I think you will agree that you have heard this evening an excellent overview and background presentation from Mrs. Pennell on licensing and certification of health services personnel. And, of course, Mr. Whyte has presented views on the complement related to human services.

But let me for a moment discuss with you an approach that is being given serious consideration, and in some ways could supercede certification, registration and/or licensure as described by Mrs. Pennell and Mr. Whyte.

I am getting ahead of my story. It should be noted that there have been serious questions raised on the national level as to the value of licensure as a means of regulating allied medical personnel. Both the American Medical Association and The American Hospital Association have called for a moratorium on licensure of any additional allied medical professions. And recently the Department of Health, Education, and Welfare issued a similar call for a two-year moratorium on licensure, and I have passed out to you some of the recommendations which HEW has made in this particular area. You'll note that HEW further recommended that in the interim a statement to the effect that a physician may delegate his responsibilities to whomever he chooses be inserted in each state's Medical Practice Act. This in effect calls for the adoption of independent practitioner control, at least for the present. And, I might add, that in Pennsylvania revisions are presently under way in the Medical Practice Act which allegedly allow for this.

Now I think all of us related to the health fields are grasping for some flexibility which licensure as such prevents. Since licensure regulations are promulgated by law, they are difficult to change, i.e., each change requiring legislative approval. Licensure standards,

as well as the educational prerequisites on which such standards are partly based, inevitably lag behind changing job requirements in an industry evolving as rapidly as health care. Educational requirements become more firmly entrenched and difficult to change when incorporated into licensure statutes. Education innovation is discouraged.

Further, licensure clearly limits what tasks may be performed by allied health personnel and thus inhibits flexibility in the use of such personnel. No cognizance can easily be taken of new needs in the health field or increasing proficiency or new skills of allied personnel. Licensure laws do not recognize the experience a health worker acquires nor the desire for delegation of new responsibilities to the employee by the employer.

So this has indeed forced us to look at still an entirely different approach to that matter and one which many in Pennsylvania have been giving deep consideration and that is a category that we might call "institutional and independent practitioner regulation." Now, under this category, the institution/independent practitioner is licensed to employ allied health personnel at its discretion and has none of the before mentioned disadvantages. However, it should be pointed out that the primary reason for regulation of allied health personnel is public protection. The question then arises whether the institutional and independent practitioner system would provide the necessary public protection. There are several arguments that support the supposition that public protection would be provided.

The first of these is legal liability. Presently, the hospital or the independent practitioner is legally responsible for the acts of the allied personnel employed. From the malpractice standpoint alone, it is clear that the hospital or the doctor must employ competent personnel; if he does not, he will shortly find himself faced with a malpractice suit. Secondly, it is clear that the doctor or the hospital in order to accomplish his job which licensure has said he is capable of doing must have

competent assistance. If someone working for a physician or a hospital is not competent, it is clear that such a person would not have a job for long. This, of course, is the same principle that works in industry, in government, and in other areas. Very few of the perhaps hundreds of thousands of different jobs are licensed; however, the supposition is not, therefore, that the people who hold these jobs are incompetent.

The training of allied medical personnel and the registry of allied medical personnel under this system would be the same as under licensure or certification. However, the hospital or the physician, and not the state government, would have the responsibility of utilizing these personnel in the best possible manner.

The differences between this system and licensure are first that the state government would not be involved in deciding whether allied medical personnel are qualified, and there would be no restrictions as to which allied medical personnel could perform what task. The government, however, would still have the responsibility of determining that both independent practitioners and institutions effectively utilize their allied medical personnel. Where under licensure there are at least potentially 200 or more allied professions to license and regulate, under institutions and independent practitioners system there are only two. On that basis, it would seem that government could better regulate those two groups to insure that the public was adequately protected.

It would be noted in the discussion of the hospital/independent practitioner system that there are some groups of allied medical personnel which are not employed by a physician or a hospital. Examples of such groups include individuals working in industry, health agencies, school health programs, rehabilitation centers, special camps, as well as those who are self-employed. It would seem that these positions would have to be filled by those who are registered or certified.

Our view then is that licensure should not be extended to additional allied health groups. As previously mentioned, this view is shared by the American Hospital Association, the American Medical Association, and the Department of Health, Education and Welfare, as well as the Pennsylvania Medical Society and The Hospital Association of Pennsylvania.

1. Our *first* choice: a system in which the doctor or the hospital, given the constraints listed above, could employ allied personnel without government restriction.

2. Our *second* choice: a system in which certification is used to regulate such allied personnel as physician's assistant, nurse midwives, pediatric nurse practitioners, and any allied profession that practices independently and registry of all other allied health professionals. Such a system, while having many disadvantages not inherent in our first choice, would allow a greater degree of flexibility and innovation than a system of licensure, while also providing close regulation of such groups as the physicians' assistants.

Group Discussion G

Dr. Robert J. Foster, Discussion Leader

Although there were only six in the group, the discussion lasted until 10:10 p.m. Contributions were free flowing and unstructured. A registered nurse from Erie who runs a nursing school helped greatly with her rational contributions gleaned from on-the-job experience.

The major points brought out by the group were:

1. the need for health-related manpower in rural areas.

2. the need for more realistic licensing procedures in which continuing education is required and which is less exclusive. Licensing should be more effective than simply setting minimum standards.

3. the need in education for field experience as a part of the formal program.

4. the need to minimize fragmentation of specialities within the paraprofessional fields. Train existing persons to do more, rather than create new specialities.

5. Why no M.D.'s at the conference?

Group Discussion H

Mr. Eugene J. Kray, Discussion Leader

The first question discussed was one of "overkill" on the part of state and professional health agencies and associations in the approval of programs and licensing of health workers. The specific issue questioned was the approval of nursing curricula including the review of faculty competence, clinical, experiences, course outlines, etc., by the State Board of Nursing Examiners. It was pointed out that after this approval, successful completion by a student of that curriculum does not necessarily qualify her to practice in the nursing profession since she must sit for the licensure examination. There was some feeling that there might not be a need for both approving the curriculum and licensure examination. It was pointed out, however, that the approval of the curriculum is to assure students who are entering that program that it meets a particular standard. It was also pointed out that the whole question of licensure and the examination process is now being reviewed by the State Board of Nursing Examiners. There was some concern on the part of the group over the statement of Mr. Whyte* relating to the inability in his areas (social work, mental health) to measure, against specific criteria, the ability of a practicing student to work in his or her area of specialization. There was no resolvement of this issue.

The second topic discussed related to the following statement by Mrs. Pennell** concerning the renewal of licenses in the health profession. "Usually the only

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*Mr. Douglas Whyte, and his presentation "Licensing and Certification: Another View."

**Mrs. Maryland Pennell, and her presentation "Licensing and Certification of Health Service Personnel."

information required is the current name and address of the practitioner. Little recognition is given to the upgrading of a person's initial qualifications by a group of continuing education."

A representative of one of the colleges mentioned a continuing education program his institution developed titled "Recent Advances in Nursing" which was aimed at practicing RN's who were away from formal nursing education for five years or more. Another program under consideration at that institution was to take inactive RN's and prepare them to reenter the labor market. The group agreed that there was a need for continuing education for all health workers periodically as a part of the renewal of licensure. It was pointed out that there is a movement underway to make continuing education at least every five years a requirement for renewal licensure.

The third topic considered was the desirability of creating a common core of courses within the allied health education field of individual institutions to allow for mobility from one field of study to another, e.g., nursing to inhalation therapy. It was felt that this was a good direction for reasons of flexibility and economy, but the problems of accreditation and approvals from the various agencies was one that might be insurmountable. Mobility from one institution to another within a health occupation area of study was considered, but the general feeling was that the number of students who transfer from one community college to another is few.

APPENDIX F

Reaction to S.V. Martorana Paper

THE ROLE OF THE UNIVERSITY IN THE PREPARATION OF ALLIED-HEALTH FACULTY FOR THE TWO-YEAR COLLEGE

Michael N. Sugarman, Assistant Professor
and Program Director of Technical Education
College of Education
University of Akron

Earlier today you heard an expert from your northern neighbor claim that he was not an expert in the area of human and health services. If Dr. Martorana, with responsibility for the entire New York State two-year college system, is a non-expert, then I must classify myself as a sub-non-expert, as I come from the state to your west where I direct one small effort in the area of allied-health technical teacher education at the University of Akron.

In the last of the eight broad concerns outlined by Dr. Martorana, he stated the need to "recognize and provide for an ample supply of competent faculty to staff the programs proposed in a state wide plan for human and health care services." In my list of major concerns, this need would head the list.

You do not have to be an expert in the area of manpower economics to understand that allied-health services, as they are supplied in the field, are staffed by allied-health technicians, who are trained in allied-health educational programs, which in turn are staffed by allied-health instructors, who may or may not be effective teachers. The point which I am trying to make here is that there may be a direct relationship between the quality of health services provided in the community and the quality of the community college faculty who train the allied-health practitioner.

The urgent demand for competent allied-health program directors and instructors is evidenced by the frequent notices of "positions available" which appear in the *Junior College Journal* and the *New York Times* classified

advertisements. The supply and demand factor of the marketplace is also reflected in salaries offered and degrees required.

New allied-health technologies seem to be created almost monthly, as you know if you are on the mailing list to receive the *Allied Medical Education Newsletter* of the American Medical Association. The September 1971 issue of the *Newsletter* listed the following rather lengthy list of allied medical occupations for which training standards are being devised:

Assistant to the Primary Care Physician
Blood Bank Specialist
Electroencephalograph Technician
Emergency Medical Technician
Medical Laboratory Technician
Urologic Physician's Assistant
Certified Laboratory Assistant
Cytotechnologist
Histologic Technician
Inhalation Therapy Technician
Medical Assistant
Medical Record Librarian
Medical Record Technician
Medical Technologist
Nuclear Medicine Technician
Nuclear Medicine Technologist
Occupational Therapist
Orthopaedic Physician's Assistant
Physical Therapist
Radiation Therapy Technologist
Radiologic Technologist

A more complete list of allied-health occupations would also include Practical Nurse and Registered Nurse among others.

Assuming that an educational program for one or more of the allied-medical occupations listed is justified in your community college, how will you find competent faculty to staff your program? The traditional approach

of raiding the faculty of other institutions only works if you can find existing programs with faculty to raid. In the area of rapidly emerging technologies another approach is demanded. Specifically, experienced practitioners in the field who already are expert in their technology may be encouraged to return to a cooperating university to learn how to become effective teachers of their technology and then return to a two-year college to train other practitioners.

The University of Akron, in cooperation with the Ohio Board of Regents and the two-year colleges of the State, has developed two programs designed specifically to prepare faculty for the career programs of two-year colleges. The programs which I refer to are the Bachelor of Science in Technical Education and the Master of Science in Technical Education degree programs.

The Bachelor of Science program is designed to prepare instructors, teaching assistants, and laboratory assistants for positions in two-year college programs. The program has two basic organizational structures. One route is based on a "two-plus-two" concept which builds upon the two-year associate degree program. The other pattern is followed by an individual who begins the program as a freshman or transfers into it at a different level.

In either case, the student will be required to have the equivalent of the technical content courses required of an associate degree graduate plus baccalaureate level courses related to the technical field. The technical content courses may be either taken at the University of Akron or transferred from another institution. Other components of the program include General Studies, Occupational Experience, and Professional Education courses directed toward teaching in the two-year college.

The program leading to the Master of Science in Technical Education provides a flexible curriculum characterized by individual planning which considers the

ALLIED HEALTH EDUCATION
College of Education
THE UNIVERSITY OF AKRON

Requirements for the Bachelor of Science in Technical Education

A. General Studies Requirements (52-65 quarter hours*)

110:111-112	English Composition	8 qtr. hrs.
110:108	Effective Speaking	4 qtr. hrs.
110:115-116-117	Institutions in the U.S.	9 qtr. hrs.
110:XXX	Physical Education	2 qtr. hrs.
110:205	Types of Literature	4 qtr. hrs.
110:303-304	Eastern Civilizations	6 qtr. hrs.
110:317-318-319	Western Cultural Traditions	12 qtr. hrs.
110:401	Senior Seminar	2 qtr. hrs.
375:141	General Psychology	5 qtr. hrs.
	Mathematics	4 qtr. hrs.*
	Science	9 qtr. hrs.*

B. Allied Health Technical Content Requirements (76-89 qtr. hours*)

The technical content courses are defined as courses in the technical specialty of allied health and those related courses in mathematics, physical science and related technical science. The specific courses required in the various technologies will be determined cooperatively between the College of Education, the Community and Technical College, and other colleges of The University which offer allied health programs.

C. Professional Requirements (29 qtr. hours)

565:157	Human Development and Learning	4 qtr. hrs.
510:401	Problems in Education	5 qtr. hrs.
510:402	Student Teaching	6 qtr. hrs.
510:403	Seminar in Student Teaching	3 qtr. hrs.
540:410	Post-secondary Technical Education	3 qtr. hrs.
540:421	Instructional Techniques in Technical Education	5 qtr. hrs.
540:430	Course Construction in Technical Education	3 qtr. hrs.

D. Occupational Experience (6 qtr. hrs.)

540:301	Occupational Employment Experience and Seminar	2-6 qtr. hrs.

E. Electives (16 qtr. hrs.)

These hours may support the student's technical field of specialization, add to the student's general education, or professional education courses.

TOTAL: 192 credits

*Since most technical education programs far exceed the general studies requirement of 13 quarter hours, math and science related to the technology is substituted. However, if the technological program does not include courses in these areas, the general studies courses are required.

background and experience as well as the goals of the student. The program is designed to enable graduate students to select advanced courses in their technical specialty, or in a special interest area, along with professional and general education courses. The purpose of the program is twofold: one, a program for the preparation of two-year college instructors, and two, a program to upgrade experienced two-year college instructors.

These two programs at the University of Akron incorporate the beliefs that in order to teach a technology effectively in a community college, the instructor must have experience as a technician, and the instructor must be trained in the art and skill of teaching his technology.

The university does have a role in the quantity and quality of health care services provided in our communities. The two-year college and the university must work cooperatively in the areas of program development, research, evaluation, curriculum revision, and as I have stressed in this paper, the area of teacher preparation.

Selected Publications Available From The Center For The Study of Higher Education

Monographs

Pennsylvania Community College Faculty -- Attitudes Toward Collective Negotiations, John W. Moore, and *Career Patterns and Educational Issues*, Robert A. Patterson, May 1971.

Institutional Self-Study at The Pennsylvania State University, Kenneth P. Mortimer and David W. Leslie (eds.), December 1971.

Numbered Reports

The Rationale for Various Plans for Funding American Higher Education, Larry L. Leslie, June 1972, Report No. 18.

Collective Bargaining: Implications for Governance, Kenneth P. Mortimer and G. Gregory Lozier, June 1972, Report No. 17.

Productivity and the Academy: The Current Condition, William Toombs, April 1972, Report No. 16.

Exceptional Graduate Admissions at The Pennsylvania State University, Manuel G. Gunne and Larry L. Leslie, March, 1972, Report No. 15.

The Quality of Graduate Studies: Pennsylvania and Selected States, Stephen D. Millman and William Toombs, February 1972, Report No. 14.

Goals and Ambivalence: Faculty Values and The Community College Philosophy, Karen L. Bloom, Angelo C. Gillie, and Larry L. Leslie, November 1971, Report No. 13.

Governance and Emerging Values in Higher Education, Kenneth P. Mortimer, Stanley O. Ikenberry, and G. Lester Anderson, September 1971, Report No. 12.

The Academic Senate at The Pennsylvania State University, Kenneth P. Mortimer, and David W. Leslie, August 1971, Report No. 11.

Professional Education: Some Perspectives, 1971, Larry L. Leslie, Kenneth P. Mortimer, and G. Lester Anderson, August 1971, Report No. 10.

Centers and Institutes at The Pennsylvania State University: A Case Study, Mary M. Norman, March 1971, Report No. 9.

New Careers in Human Services: A Challenge to the Two-Year College (A Preliminary Report), Martha A. Burns, March 1971, Report No. 8.

The Academy and General Education, Stanley O. Ikenberry, December 1970, Report No. 7.

Numbered Reports (cont'd)

A Profile of Proliferating Institutes: A Study of Selected Characteristics of Institutes and Centers in 51 Land Grant Universities, Stanley O. Ikenberry, November 1970, Report No. 6.

Roles and Structures for Participation in Higher Education Governance: A Rationale, Stanley O. Ikenberry, August 1970, Report No. 5.

Conference Reports

The Second Annual Pennsylvania Conference on Post-Secondary Occupational Education, Angelo C. Gillie, June 1970.

Post-Secondary Occupational Education: An Overview and Strategies, Angelo C. Gillie, January 1970.

Bibliographies

The Black Student in Higher Education: A Bibliography, W. Frank Hull IV, November 1969, Number 3.

Student Unrest on the American Campus: A Bibliography, David W. Leslie, November 1969, Number 2.